

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05532 CERTIFICATE OF DEATH 05526									
1. DECEASED-NAME (Type or print) <i>Sidney</i>			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
<i>Alexander</i>			<i>NMI</i>			<i>April 27 69</i>			<i>450A M</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5-13-84</i>		6. AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>AUTO DEALER</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>AUTO</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>POTOMAC</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			13e. STREET AND NUMBER <i>8417 FOX RUN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>220-03-0285</i>			17. INFORMANT <i>ROGER ALEXANDER - SAME AS #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Fibrosis & Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Chronic Pulmonary Disease, Urinary Retention</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year +</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Suprapubic</i> <i>Arteriosclerotic Heart Disease, Generalized Arteriosclerosis, Cystitis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from <i>4/16/69</i> , 19__, to <i>4/27/69</i> , 19__, that (we) last saw the deceased alive on <i>4/27/69</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frederick S. Caldwell MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-27-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>FREDERICK S CALDWELL MD</i>				22e. ADDRESS <i>ROCKVILLE MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-29-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL MEMORIAL PK</i>		23d. LOCATION (City or Town) (County) (State) <i>FALLS CHURCH, VA.</i>			
24. FUNERAL DIRECTOR <i>JOS. GAWLER'S SONS</i>				ADDRESS <i>5130 WISCONSIN AVE. WASHINGTON, D.C.</i>		25a. REC'D BY REGISTRAR <i>MAY 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

SECRET

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05527

05533

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) WESLEY			First Middle Last GEORGE ALLEN			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Apr. Day 10, Year 1969			2b. HOUR 1:30A				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH Dec. 25, 1924		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Florida			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery				
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodian				12b. KIND OF BUSINESS OR INDUSTRY U.S. Post Off.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland Prince George				13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 816 Rittenhouse Street					
14. FATHER'S NAME First Middle Last George Allen						15. MOTHER'S MAIDEN NAME First Middle Last Amy Puleston							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW2 Army						16b. SOCIAL SECURITY NO.		17. INFORMANT Juanita Allen - wife ADDRESS 816 Rittenhouse St. Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive spontaneous, 4309 DUE TO, OR AS A CONSEQUENCE OF (b) subarachnoid hemorrhage apparently DUE TO, OR AS A CONSEQUENCE OF (c) from Circle of Willis region. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Read				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED April 10, 1969					
EXAMINER'S NAME (Type) BELDEN R. READ, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, or County)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR John H. Stewart Jr. ADDRESS Stewart Funeral Home-4001 Benning Road,						25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

0520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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45M -

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05534 CERTIFICATE OF DEATH 05528										
1. DECEASED NAME (Type or print) First Middle Last <i>Edith P Allnutt</i>			2a. DATE OF DEATH Month Day Year <i>April 3 1969</i>			2b. HOUR M <i>1P</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>9/20/90</i>		6. AGE (In years last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Montg</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>25 Williams St.</i>	
14. FATHER'S NAME First Middle Last <i>Alexander F Prescott</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Edith Stonby Kellogg</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>218-346471</i>		17. INFORMANT <i>Stedman Prescott-7001 Chevy Chase, Maryland 20015</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of uterus (endometrial)</i> <i>1820</i> DUE TO, OR AS A CONSEQUENCE OF <i>with regional metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-5 yrs.</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/3</i> , 19 <i>69</i> , to <i>4/3</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>4/3</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Arthur F. Woodward</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>April 3-1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>Arthur F. Woodward</i>					22e. ADDRESS <i>Rockville - Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/5/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rockville</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>				
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>					ADDRESS <i>1331 Rock Pike</i>		25a. REC'D BY REGISTRAR <i>APR 7 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
					DATE <i>APR 7 1969</i>					

05236

CERTIFICATE OF MARRIAGE

05236

Lyons Hospital, Kansas City, Mo.
April 1, 1933
Certificate of Marriage

Myself, M.D.

Witness

Witness

April 1, 1933

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in lines 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

05535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05529

1. DECEASED NAME (Type or Print) First Middle Last JOHN J. ASERO			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year APRIL 10 1969			2b. HOUR 9:30 P.M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 9/15/1912	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year APRIL 10 1969	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH BIETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Librarian - Defense Support Agency		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Salvatore Asero		15. MOTHER'S MAIDEN NAME First Middle Last Angela Bellia		17. INFORMANT (Wife) Vera Asero			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. 4109 1942-45 577-58-0270		17. ADDRESS 11975 Andrew St., Wheaton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency with thrombosis; 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED APRIL 11, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 15, 1969		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR C. Glen Carter		ADDRESS 8434 Georgia Avenue		25a. RECD BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	
Warner E. Pumphrey, Inc.		Silver Spring, Maryland					

FILE NO. 100-100000
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05536										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05530																																																	
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																	
First JOHN										Middle BRADEN										Last BAILEY										Month APRIL										Day 28										Year 1969										7:47AM									
3. SEX MALE										4. RACE CAUCASIAN										5. DATE OF BIRTH JUNE 12, 1923										6. AGE (In years last birthday) 45 YRS.										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS. HOURS MIN.																			
7a. BIRTHPLACE (State or foreign ADA, OKLAHOMA										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED WIDOWED										NEVER MARRIED										DIVORCED										9. COUNTY OF DEATH MONTGOMERY										Md.									
10. CITY OR TOWN OF DEATH BETHESDA										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital NAVAL HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U. S. NAVY										12b. KIND OF BUSINESS OR INDUSTRY MILITARY																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) VIRGINIA										13b. CITY OR TOWN FAIRFAX										13c. CITY OR TOWN MC LEAN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 1322 BANQUO COURT																													
14. FATHER'S NAME First CHARLES										Middle JACKS										Last BAILEY										15. MOTHER'S MAIDEN NAME First ALPHA										Middle ONA										Last BRADEN																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES										16b. SOCIAL SECURITY NO. WWII, KOREA, RVN 446-12-2269										17. INFORMANT MRS. HARRIET T. BAILEY										1322 BANQUO CT., MC LEAN, VA. 22101																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) 2d52 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										MENINGIOMA, POSTERIOR CRANIAL FOSSA, STATUS POST OPERATIVE CRANIOTOMY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																																					
19a. DATE OF OPERATION APR 25, 1969										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Meningioma										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																																	
22a. I certify that (this hospital) attended the deceased from NOV. 4, 1968, to APR. 28, 1969, that (we) last saw the deceased alive on APR 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																																					
22b. SIGNATURE J. P. WISSINGER										DEGREE LDR MC USNR										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 29 April 1969																																							
22d. PHYSICIAN'S NAME (Type) J. P. WISSINGER										22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 5-5-69										23c. LOCATION (City or Town) (County) (State) SAN DIEGO, CALIF.																																																	
24. FUNERAL DIRECTOR W. W. CHAMBERS										ADDRESS 1400 Chapin St., N.W., Washington D. C.										25a. REC'D BY REGISTRAR DATE MAY 6 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																																							

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used to analyze the data, and the results of the analysis. The third part of the report is a discussion of the results of the study and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used to analyze the data, and the results of the analysis. The third part of the report is a discussion of the results of the study and their implications. This includes a comparison of the results with previous studies and a discussion of the limitations of the study. The final part of the report is a conclusion and a list of references.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-1
304M REV. 1-68

05537		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05531	
Item 1 Film 411 4/21/69 kk					
1. DECEASED-NAME (Type or print) Raymond MAXFIELD			2a. DATE OF DEATH 4 Month 9 Day 69 Year		2b. HOUR 12 PM
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 10/7/12	6 AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) IOWA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		Md.
10 CITY OR TOWN OF DEATH SILVER SPRING	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, admission) STATE MD.	13b. COUNTY Bethesda	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 7609 Wadsworth Dr.	
14. FATHER'S NAME First Middle Last Raymond Charles Barnes		15 MOTHER'S MAIDEN NAME First Middle Last Susanna Thornell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Unknown (If yes give war or dates of service)		16b SOCIAL SECURITY NO 480-09-918	17. INFORMANT Address Margaret Barnes 9690 Wadsworth Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Failure DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few days 15 mos					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Oct 1967, to 4/9, 1969, that (I) (we) last saw the deceased alive on 4/9 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. Leonard Gold		22c. DATE SIGNED 4/9/69	22d. PHYSICIAN'S NAME (Type) G. Leonard Gold		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-12-69	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City or Town) (County) (State) Rockville Md. Mont. Co.	
24 FUNERAL DIRECTOR Robert A. Pumphrey 7557 Wisc. Ave. Beth		25a. BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05538										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05532	
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR	
First Middle Last										Month Day Year										OF	
Notley Howard Barrett										April 22 69										11 P	
3 SEX		4. RACE		5 DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		White		5-13-99				69 YRS.				MONTHS DAYS		HOURS MIN							
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.									
Maryland		U.S.				Montgomery															
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INST. TUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY									
Takoma Park				Washington San & Hosp.				Retired				Cap. Transit									
13a USLA RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER											
Maryland				136 Prince Georges		Beltsville				11704 Chilcoate Lane											
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last																	
Henry Barrett				Mary C. Cook																	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO.		17. INFORMANT				Address				Same as							
no						Mary EXX I. Miller (Dau.)				# 13											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>														minutes							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL HEMORRHAGE</u>														4 days							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSION</u>																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CONGESTIVE HEART FAILURE + old CVA.</u>																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)				21f LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>4-18</u> , 19 <u>69</u> , to <u>4-22</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-22</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.																					
22b SIGNATURE <u>John L Ford MD</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c DATE SIGNED <u>4-23-69</u>											
22d PHYSICIAN'S NAME (Type) <u>JOHN LOUIS FORD</u>										22e ADDRESS <u>831 UNIVERSITY BLVD E. SILVER SPRING, MD. 20803</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)											
Burial				4/26/69		Gate Of Heaven				Wheaton, Maryland											
24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS <u>Wash., DC</u> 25a REC'D BY REGISTRAR <u>APR 25 1969</u> 25b REGISTRAR'S SIGNATURE <u>William J. Judge</u>																					
25. <u>Simmons Bros. 1661- Good Hope Rd. SE</u>																					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05539

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05533

1. DECEASED-NAME (Type or Print) William Howard Barringer			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 3 Year 69			2b. HOUR 12:30			
3 SEX M.	4. RACE W	5. DATE OF BIRTH 7-15-03	6 AGE (In years or birthday) 65 YRS.	7 UNDER 1 YEAR MONTHS 0 DAYS 0	8 UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 4 Day 3 Year 1969			
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Jakoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San & Hosp			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - U. S. Army		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Jakoma Park		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 8502 Garland Ave. T.P., Md.	
14. FATHER'S NAME First William Middle Barringer Last Barringer			15. MOTHER'S MAIDEN NAME First Anna Middle Fruend Last Fruend						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II			16b. SOCIAL SECURITY NO. Yes			17 INFORMANT Takoma Park, Md. ADDRESS 8502 Garland Ave. Mrs. Marie L. Barringer Silver Spring			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Pancreas with 157.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastasis DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED APRIL 3, 1969			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City, town, or county) Washington			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery		23d. LOCATION (City or Town) (County) (State) Burtonsville, Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		DATE APR 11 1969		REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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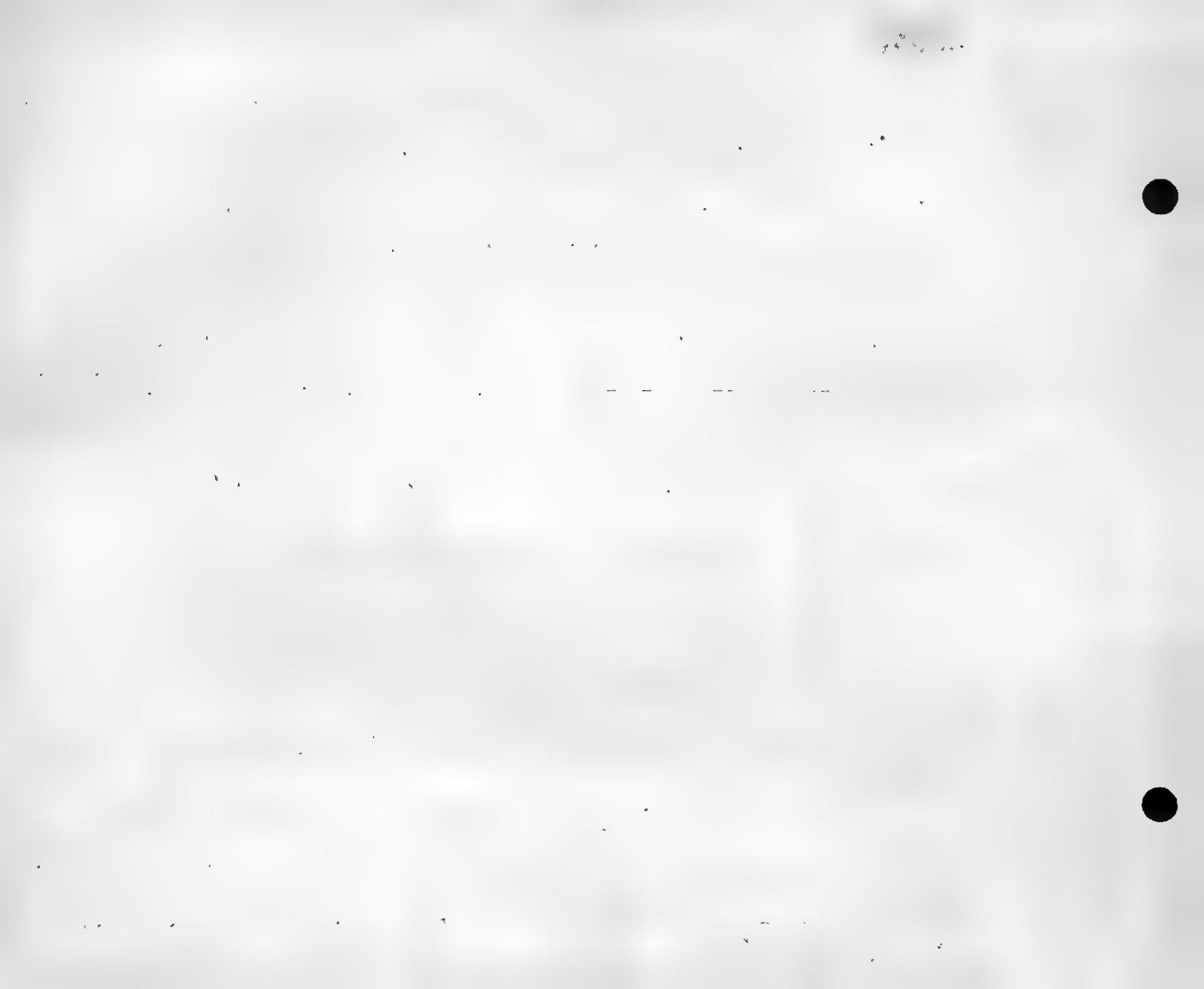
05540

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05534

1. DECEASED-NAME (Type or print) XXXXXX LAURA NAOMI BEALL			2a. DATE OF DEATH Month Day Year APRIL 23 1969			2b. HOUR 10 ⁰⁰ AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH February 17, 1880		6. AGE (In years last birthday) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery, Md				
10. CITY OR TOWN OF DEATH Bethesda.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5720 Huntington Parkway			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 342 East Third Street	
14. FATHER'S NAME First Middle Last Curtis Michael			15. MOTHER'S M.A.DEN NAME First Middle Last Mary Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 214-10-5834D		17. INFORMANT Address Bethesda, Md. Mrs. William E. Ross 570 Huntington Pkwy.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 1542 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANNULAR CARCINOMA OF RECTUM DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12/27, 1966, to present, 19, that (I) (we) last saw the deceased alive on 3/25/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Irving Lowell Marks M.D.						22c. DATE SIGNED 4/23/69				
22d. PHYSICIAN'S NAME (Type) Dr. Irving Lowell Marks M.D.						22e. ADDRESS 320 University Blvd. East Sil. Sp. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-26-1969			23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR Robert E. Dailey & Son						25. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE William J. Ind...		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

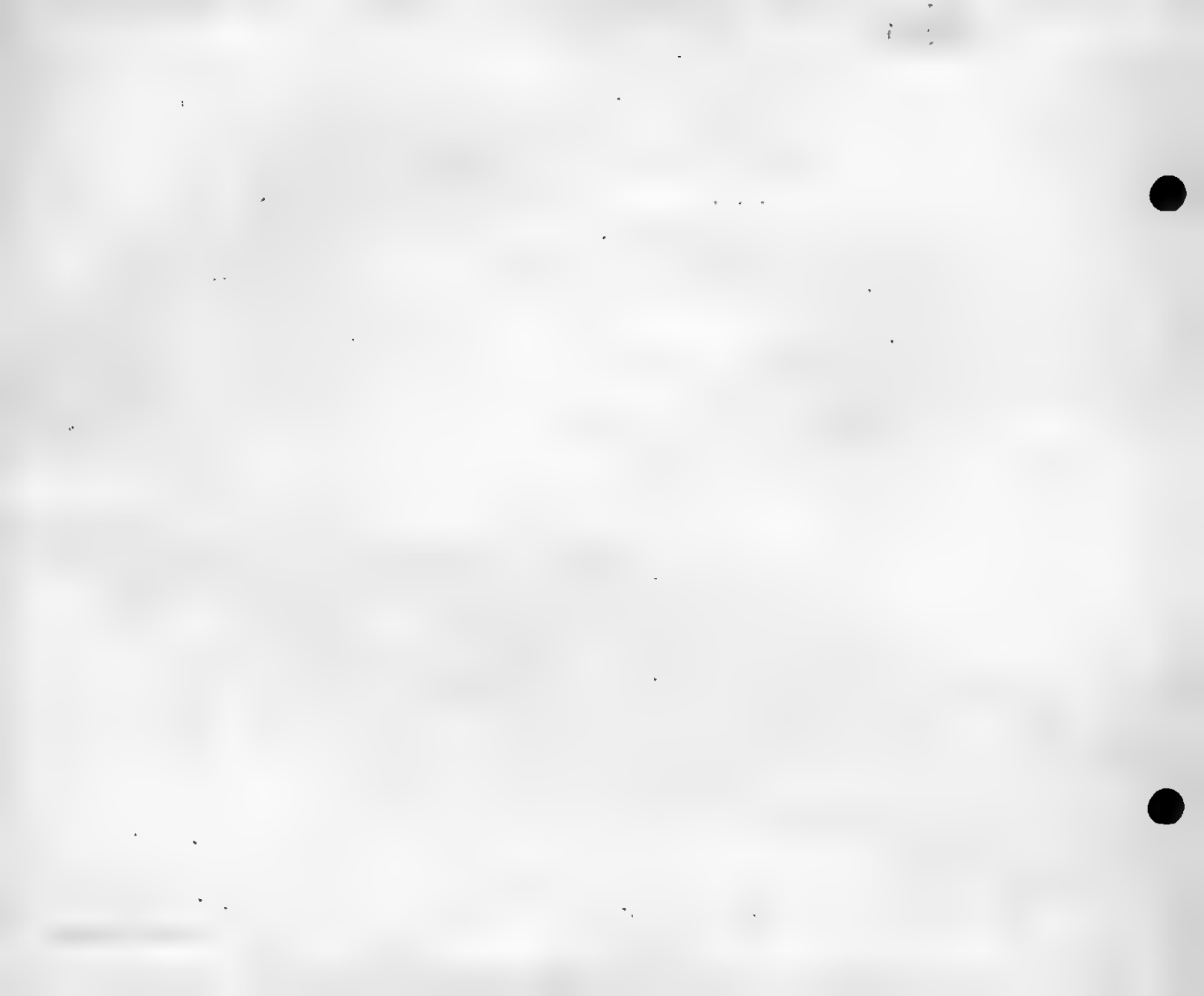
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05541

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05535

1. DECEASED-NAME (Type or Print) Mary			First Middle Last V. Beard			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> April 4 1969			2b. HOUR 2:30 AM				
3. SEX F		4. RACE Negro		5. DATE OF BIRTH 10/9/00		6. AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE D.C.				13b. COUNTY 1		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 744 Girard St., N.W.			
14. FATHER'S NAME Charles				First Middle Last Taper		15. MOTHER'S MAIDEN NAME Lillie				First Middle Last Finhey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO		17. INFORMANT Son - Lucien Bannister				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease - DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fracture of Left Hip.													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 4/2/ 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Fall at home where employed.					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No City or Town County State 3715 Cherry Chase Rd., Bethesda Montgomery Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John S. Bell				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED April 4, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 4-8-69		23c. NAME OF CEMETERY OR CREMATORY Oriskany Cemetery				23d. LOCATION (City or Town) (County) (State) Winchester Spg. Va			
24. FUNERAL DIRECTOR Costantino Funeral Home				ADDRESS 1550 Corn St.				25a. RECEIVED BY REGISTRAR APR 8 1969				25b. SIGNATURE OF REGISTRAR John S. Bell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05542

MARTYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05536

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last JAMES F. BEAVERS			2a. DATE OF DEATH Month Day Year APR 20 1969			2b. HOUR 6:40 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10/16/96		6. AGE (In years lost birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol. give street address) Holy Cross Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Cherry Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER 2912 Terrace Drive		14. FATHER'S NAME First Middle Last Maurice Beavers		15. MOTHER'S MAIDEN NAME First Middle Last Sarah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) No		16b. SOCIAL SECURITY NO. 577-03-0948A		17. INFORMANT Faye J. Schaeffer		18. ADDRESS 321 Scott Dr. Sec 4, 7th fl.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage							
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis							
DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary emphysema							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 4-9 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-9 1969 to 4-20 1969 , that (I) (we) last saw the deceased alive on 4-19 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. I. Shapin				22c. DATE SIGNED 4-20-69			
22d. PHYSICIAN'S NAME (Type) M. I. SHAPIN				22e. ADDRESS HOLY CROSS HOSP			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-23-69		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d. LOCATION (City or Town) (County) (State) COLUMAR MANOR MD.	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co.		ADDRESS 1400 CHAPIN ST. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR APR 22 1969		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO HOSPITAL ... ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

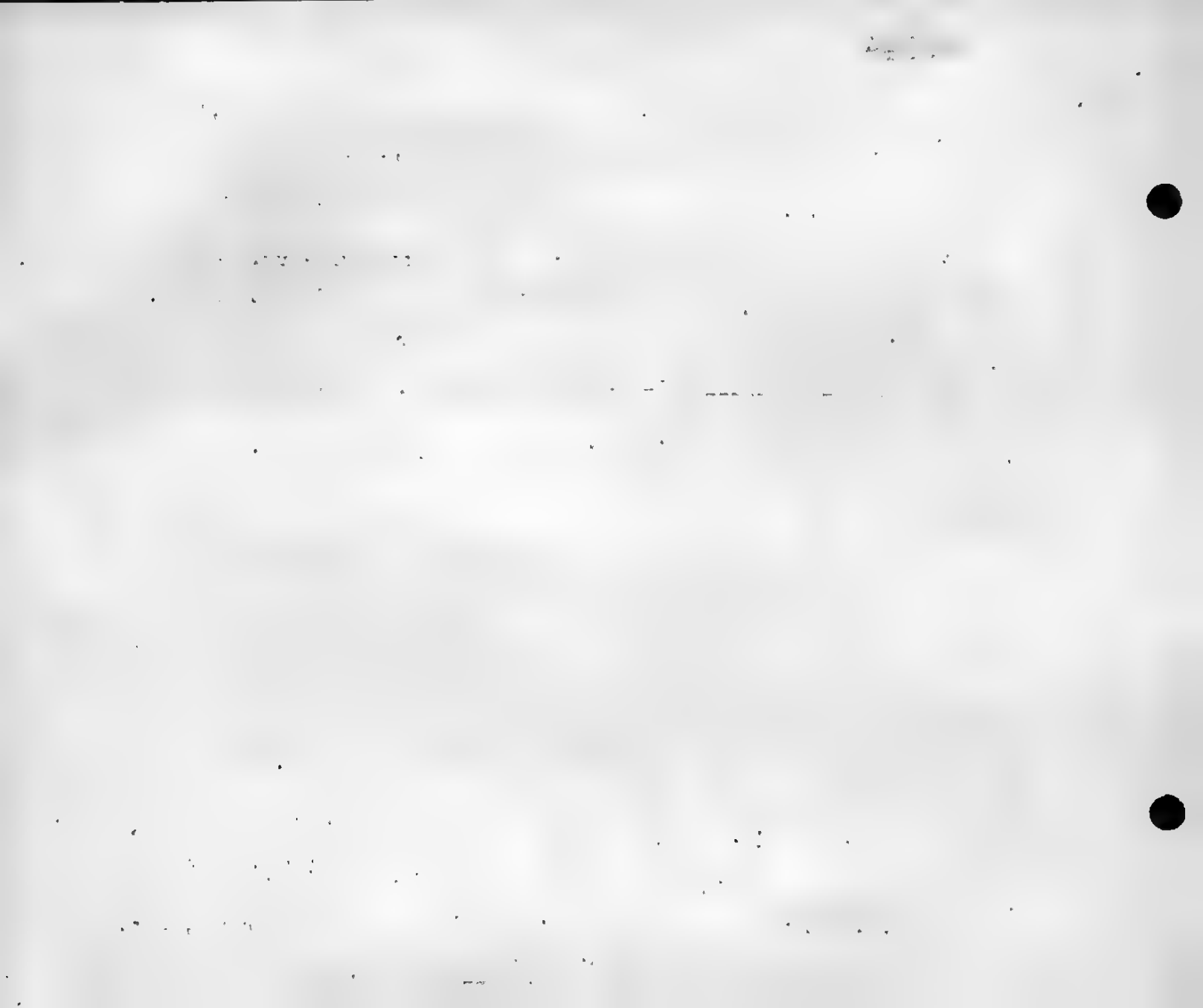
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05543		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05537	
1 DECEASED-NAME (Type or print) <i>Henry A Belding</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>22</i> Year <i>1969</i>		2b. HOUR <i>4:40 PM</i>		
3 SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>3-18-86</i>		6 AGE (In years last birthday) <i>83</i> YRS.	
7a BIRTHPLACE (State or foreign country) <i>MD</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>ENG. ENGINEER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>PLUMBING</i>	
13a USUAL RES. (Where deceased lived, if institution Residence before admission) STATE <i>D.C.</i>		13b. COUNTY <i>—</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>4842 DAVENPORT ST N.W.</i>		14 FATHER'S NAME First <i>HENRY</i> Middle <i>—</i> Last <i>BELDING</i>		15 MOTHER'S MAIDEN NAME First <i>N/A</i> Middle <i>—</i> Last <i>—</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)		16b SOCIAL SECURITY NO. <i>577-03-0907</i>		17. INFORMANT <i>Wife Mrs Nellie F Belding</i>		Address <i>Same as above</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>16 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pulmonary Emphysema</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>August 1957</i> to <i>April 1969</i> , that (I) (we) last saw the deceased alive on <i>April 21, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>C. Roger Kurtz, MD</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4-22-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>C. Roger Kurtz, MD</i>		22e. ADDRESS <i>3701 Connecticut Ave NW Wash DC</i>		22f. ADDRESS			
23a BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>4/25/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEM</i>		23d LOCAT ON (City or Town) (County) (State) <i>WASHINGTON, D.C.</i>	
24 FUNERAL DIRECTOR <i>JOS. GAWLER'S SONS</i>		ADDRESS <i>5130 WILSON AVE. WASHINGTON, D.C.</i>		25a REC'D BY REGISTRAR <i>APR 25 1969</i>		25b REGISTRAR'S SIGNATURE <i>William S. Judge</i>	

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closed by Dr. John Bell - coroner

05544										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05538									
1. DECEASED-NAME (Type or print) First Middle Last FLORENCE M. BELL										2a. DATE OF DEATH Month Day Year April 8, 1969										2b. HOUR 4:21 AM									
3. SEX Female					4. RACE White					5. DATE OF BIRTH January 5, 1902					6. AGE (In years last birthday) 67 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) Washington, D.C.					7b. CITIZEN OF WHAT COUNTRY? US					B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md.														
10. CITY OR TOWN OF DEATH Rockville					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 215 Beall Ave.					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) XXXXXXXXXXXX Retired					12b. KIND OF BUSINESS OR INDUSTRY US Govt.														
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland					13b. COUNTY Montgomery					13c. CITY OR TOWN Rockville					13d. INSIDE CITY L.M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 215 Beall Ave.									
14. FATHER'S NAME First Middle Last Harry Hooper					15. MOTHER'S MAIDEN NAME First Middle Last Clara Barse																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16b. SOCIAL SECURITY NO. 577-22-2184					17. INFORMANT Address Charles N. Bell-same item # 13A																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-28</u> , 19 <u>68</u> , to <u>4-8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-7-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>D L. Bueh / R. C. Macdon</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 4-8-69														
22d. PHYSICIAN'S NAME (Type) <u>D L. Bueh / R. C. Macdon</u>										22e. ADDRESS <u>834 Veirs Mill Rd Rockville, Md</u>																			
23a. BLR A., CREMATION, REMOVAL (Specify)					23b. DATE 4/8/69					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery					23d. LOCATION (City or Town) (County) (State) Prince George, Maryland														
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>										ADDRESS <u>1331 Rock Pike Rockville, Maryland</u>					25a. REC'D BY REGISTRAR <u>APR 9 1969</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



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Approved by coroner - Dr. Ruppert

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
05545		05539									
1. DECEASED NAME (Type or print)		First <u>Leon</u>		Middle		Last <u>Benefiel</u>		2a. DATE OF DEATH		2b. HOUR	
XXXXXXXXXX <u>Guisinger</u>		XXXXXX		XXXXXX		<u>APRIL</u>		Month <u>10</u> Day <u>10</u> Year <u>1969</u>		<u>6 P M</u>	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN	
<u>MALE</u>		<u>White</u>		<u>Feb. 22, 1892</u>		<u>77</u> YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
<u>Indiana</u>		<u>U.S.A. - America</u>				<u>Montgomery</u>				<u>Mo</u>	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
<u>TAKOMA PARK</u>		<u>WASHINGTON SANITARY HOSP.</u>		<u>Retired Supervisor</u>		<u>Post Office</u>					
13a. USUAL RESIDENCE (Where deceased lived at last admission) STATE		13b. CITY OR TOWN		13c. STREET AND NUMBER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<u>Maryland</u>		<u>PRINCE GEORGE</u>		<u>AUREL</u>		<u>16031 Terald Rd.</u>					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
First <u>Joel</u> Middle <u>Leon</u> Last <u>Benefiel</u>		First <u>Jeannette</u> Middle <u>Guisinger</u> Last <u>Guisinger</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		7 INFORMANT		Address					
<u>YES</u>		<u>WHT</u>		<u>?</u>		<u>HOSPITAL RECORDS</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u>										<u>1 hr</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute hypoglycemia</u>										<u>3-4 hrs.</u>	
(c) <u>arteriosclerosis & diabetes</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Thrombosis 1964 & 1966. Recent viral infection & asthma</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1968, to <u>April 10</u> , 1969, that (I) (we) lost the deceased alive on <u>April 10</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<u>Lydney Leventhal, M.D.</u>		<u>April 10, 1969</u>		<u>Lydney Leventhal, M.D.</u>		<u>9210 Colesville Rd., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>4/14/1969</u>		<u>Gate of Heaven Cemetery</u>		<u>Silver Spring, Maryland</u>					
24. JUNE 1 DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<u>Warner E. Pumphrey, Inc.</u>		<u>APR 17 1969</u>		<u>Charles Judge</u>							

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1

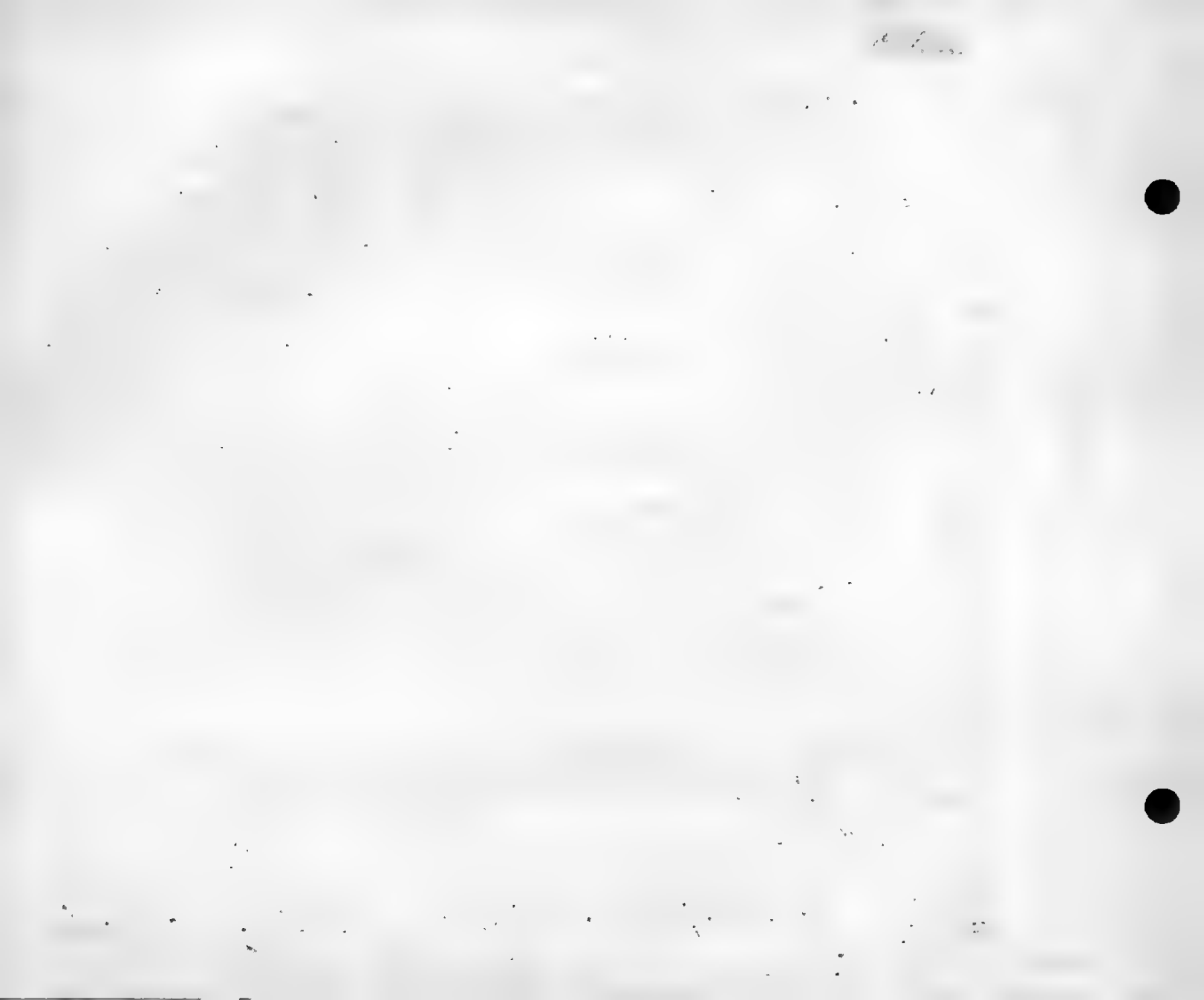
05546

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05540

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) WILLIAM ANTHONY BENJAMIN			2a. DATE OF DEATH Month April Day 1 Year 1969			2b. HOUR M 	
3. SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MAY 8, 1884		6 AGE (In years lost birthday) 84 YRS.	
7a. BIRTHPLACE (State or foreign country) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) COLONIAL VILLA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) INSURANCE		12b. KIND OF BUSINESS OR INDUSTRY SALARIED	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN MD.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3452 CHISWICK COURT							
14 FATHER'S NAME First Middle Last THOMAS BENJAMIN			15. MOTHER'S MAIDEN NAME First Middle Last WILHELMINA DECKER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 		17 INFORMANT Address MRS. MARJORY I. DREW			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia 4x5x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 d
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Sen. A.S.E. CVA, CHF							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-12, 1968 to 4-1, 1969 , that (I) (we) last saw the deceased alive on 3-28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Abraham W. Danish		DEGREE 		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-2-69	
22d. PHYSICIAN'S NAME (Type) ABRAHAM W. DANISH		22e. ADDRESS 1106 SPRING ST. S.S.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE APR 4 1969		23c. NAME OF CEMETERY OR CREMATORY FRANKLIN FEM		23d. LOCATION (City or Town) (County) (State) Beltsville - AGEO Md.	
24. FUNERAL DIRECTOR Arthur Walters		ADDRESS 254 Carroll St. - DC		25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE John J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item # 1F		7/2/69		MARYLAND STATE DEPARTMENT OF HEALTH	
05547		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH					
1 DECEASED NAME (Type or print)		First Peter Middle Last		2a. DATE OF DEATH Month Day Year	
3 SEX M		4 RACE W		5 DATE OF BIRTH April 19, 1969	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (In years last birthday) YRS MONTHS DAYS	
7c. MARIED WIDOWED		8 NEVER MARRIED DIVORCED		9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Suburban		12a USAL OCCUPATION (Kind of work done during most of working life, even if retired) 12b. KIND OF BUSINESS OR INDUSTRY	
13a USAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville	
14 FATHER'S NAME First Middle Last John Ludwig Berg		15. MOTHER'S MAIDEN NAME First Middle Last Sharon Ruth Haegeist		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
16b SOCIAL SECURITY NO		17 INFORMANT Father		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intrauterine compression of umbilical cord</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from April 19, 1969, to April 19, 1969, that (I) (we) last saw the deceased alive on April 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE James A. Davis Jr M.D.		22c. DATE SIGNED April 19, 1969		22d. ADDRESS 8218 Wisconsin Ave, Bethesda	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4/23/69		23c NAME OF CEMETERY OR CREMATORY Rockville Cemetery	
23d. LOCATION (City or Town) (County) (State) Rockville, Maryland		24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock Pike Rockville, Maryland		25a REC'D BY REGISTRAR APR 24 1969	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) BERTHA NMN BERNHARD						2a. DATE OF DEATH Month 4 Day 26 Year 69			2b. HOUR 7:45 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 9-4-96		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LABORER FOR U.S. DEPT. OF INDUSTRY			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SANDY SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER FRIENDS HOUSE			
14. FATHER'S NAME First Middle Last LEWIS -- VIOLET				15. MOTHER'S MAIDEN NAME First Middle Last LYDIA -- JENKS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>			16b. SOCIAL SECURITY NO 220-34-8515			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA - TERMINAL 4319 DUE TO, OR AS A CONSEQUENCE OF CEREBRAL HEMORRHAGE - PONTINE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last ARTERIOSCLEROSIS - GENERALIZED (b) 3 WKS (c) YRS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSED DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1964 , 19-- to 4/26 , 19 69 , that (I) (we) last saw the deceased alive on 4/26/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald R. Lewis MD				22c. DATE SIGNED 4/26/69		22d. PHYSICIAN'S NAME (Type) DONALD R LEWIS		22e. ADDRESS BURTONSVILLE MD			
23a. BURIAL CREMATION, REINTERMENT (Specify)		23b. DATE APRIL 26 1969		23c. NAME OF CEMETERY OR CREMATORY LEE FUNERAL HOME		23d. LOCATION (City or Town) (County) (State) WASH. D.C.					
24. FUNERAL DIRECTOR Francis H. Barber				25a. REC'D BY REGISTRAR Raytonsville		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 1 1969			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05549										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05543									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED NAME (Type or Print)					First <u>SAMUEL</u> Middle <u>BERKMAN</u> Last <u>BERKMAN</u>					2a. DATE KNOWN OF DEATH					Month <u>4</u> Day <u>11</u> Year <u>1969</u>					2b. HOUR <u>5:45</u> AM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. UNDER 1 YEAR			8. IF UNDER 24 HRS			2c. DATE PRONOUNCED DEAD					2d. HOUR						
male			cauc			July 1890			78 YRS			MONTHS DAYS			HOURS MIN			Month <u>4</u> Day <u>11</u> Year <u>1969</u>					5:45						
7a. BIRTHPLACE (State or foreign country)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH														
RUSSIA					U. S. A.										Montgomery Md														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring					916 Clintwood Dr. S.S.										Carpenter														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
Md					Montgomery					Silver Spring					YES					916 Clintwood Drive									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
First Middle Last Mayer Berkman					First Middle Last Unascertainable																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS														
No					225-05-3462					Albert Berkman (son)					916 Clintwood Dr. Silver Spring, Md														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																													
PART 1. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u>																													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u>																													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
22b. DATE SIGNED																													
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>										ADDRESS (Type, city, town, or county) <u>Falls Church, Virginia</u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
BURIAL					Apr. 13, 1969					King David Memorial Garden					Falls Church, Virginia														
24. FUNERAL DIRECTOR <u>Donald M. Stein</u>										ADDRESS <u>232 Carroll St., N.W. Wash., D.C.</u>										25a. RECEIVED BY REGISTRAR <u>APR 15 1969</u>									
Hebrew Memorial Funeral Home																				25b. COUNTY PARSONS SIGNATURE <u>John B. Judge</u>									



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05550

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH**

05544

1. DECEASED NAME (Type or print) JOSEPH		Middle BERNARD		Last BERNARD		2a. DATE OF DEATH Month Day Year APRIL 26 1969		2b. HOUR 10 P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/12/02		6. AGE (In years last birthday) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) N.Y.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SUBURBAN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Commerce Dept. of U.S. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY		12c. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE DISTRICT OF COLUMBIA		13b. COUNTY WASHINGTON		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3470 39TH ST	
14. FATHER'S NAME First Middle Last HARRY BERNARD		15. MOTHER'S MAIDEN NAME First Middle Last ROSA AMBRUNY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or Unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		16c. INFORMANT James Bernard Address Bridgeton N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION RECENT & REMOTE DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERIOSCLEROSIS WITH THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF (c) 		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 20 Apr 1969 , to 26 Apr 1969 , that (I) (we) last saw the deceased alive on 26 Apr 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Robert T. Kelley		22c. DATE SIGNED 26 Apr 69					
22d. PHYSICIAN'S NAME (Type) ROBERT T KELLEY		22e. ADDRESS 1302-18th St. NW. D.C.							
23a. (U.R.A.) CREMATION, REMOVAL (Specify) 4/30/69		23b. DATE 4/30/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Park Cem.		23d. LOCATION (City or Town) (County) (State) PARANUS, N.J.			
24. FUNERAL DIRECTOR BERNARD DANZOWSKY WONS		ADDRESS 3501-14th St. NW WASH. D.C.		25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE William J. Rudee			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05551 CERTIFICATE OF DEATH 05545									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR A
Stanley Leon Betesh						April 1, 1969			7:50 M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Male		White		10 July 1943			25 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Washington, D.C.		U.S.A.					Montgomery Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Store Owner		Self-employed	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Montgomery			Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			13e. STREET AND NUMBER			
Leon Betesh			Alice Betesh			1111 University Blvd., West			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			578-56-1254			The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive Pulmonary Infiltration with/</u> <u>201X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hodgkin's Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from <u>12 February, 1969</u> to <u>1 April, 1969</u> , that <u>XIX</u> (we) lost saw the deceased alive on <u>1 April, 1969</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I)</u> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Clarence H. Brown, M.D.</u> 22b. PHYSICIAN'S NAME (Type) Dr. Clarence H. Brown					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 1 April 1969		
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		4/1/69		Ohev Sholom Talmud Torah			Washington, D. C.		
24. FUNERAL DIRECTOR Bernard Danzansky & Sons 3501 14th St., NW., Wash., D.C.					25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

05552		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05546			
1 DECEASED-NAME (Type or print) First Middle Last						2a. DATE OF DEATH Month Day Year		2b. HOUR	
Joseph F. BETHERLEY						April 28 1969		3:15 A.M.	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER YEAR MONTHS DAYS	
m.		W		6/19/01		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
New York		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Bethesda				5004 Woodland Lane	
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last							
JOHN Joseph BUTTERLEY		CATHERINE JULIANN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No				Evelyn BETTERLEY - WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4377 ORGANIC BRAIN SYNDROME w PSYCHOSI DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS 3 YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from FEB 27, 1968, to APRIL 28, 1969, that (I) (we) last saw the deceased alive on APRIL 27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert G. Angle M.D.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED APRIL 28, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Apr 30, 1969		Oak Hill Cemetery		Washington, D.C.			
24. FUNERAL DIRECTOR H. Don DeVol		ADDRESS 2222 Wis. Ave. Wash. D.C.		25a. RECEIVED BY REGISTRAR MAY 3 1969		25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The following requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 3
45M - 10-69

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) Frank		First Frank		Middle A.		Last Biberstein Jr.		Date of Death Month April Day 30 Year 1969		2b HOUR 2:30 AM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 6-7-00		6. AGE (In years last birthday) 68 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery				Md
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Physician		12b. KIND OF BUSINESS OR INDUSTRY Catholic Union				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before death) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10225 Kensington Hwy		
14. FATHER'S NAME First Frank Middle A. Last Biberstein Sr.		15. MOTHER'S MAIDEN NAME First Sarah Middle Malone Last Malone								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.		16b. SOCIAL SECURITY NO 578-05-4242		17. INFORMANT Shirley T. Biberstein - wife - (old name)		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from about June 19 68 , to 4/30 , 19 69 , that (I) (we) lost saw the deceased alive on 4/30 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Richard H. Pollen MD		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/30/69				
22d. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN MD		22e. ADDRESS 10400 CONNECTICUT AV KENSINGTON MD								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-2-1969		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery Co., Md				
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC				ADDRESS 5130 WISC. AVE., N. W. WASH., D. C. 20016		25a. REC'D BY REGISTRAR MAY 6 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05554

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05548

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P		
Frances Margaret Bonta						April 2, 1969			4:00 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		22 October 1910		58 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Tennessee		U.S.A.				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center, NIH			Credit clerk			Oil Company		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Virginia			Arlington		Arlington			716 N. Tazewell Street			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Julius Moody						Cara May Alice Bauer.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT			
no						085-03-8044		The Medical Record Address The Clinical Center, NIH, Bethesda Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>17</u> DUE TO, OR AS A CONSEQUENCE OF Peritonitis and Diverticulitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with perforation of sigmoid colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Carcinoma of the breast</u> APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>hours</u> <u>few</u> <u>hours-days</u> <u>9 years</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9 February, 1969</u> , to <u>2 April, 1969</u> , that (I) (we) last saw the deceased alive on <u>2 April, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Itamar B. Abrass, M.D.</u>						DEGREE		22c. DATE SIGNED 2 April 1969			
22d. PHYSICIAN'S NAME (Type) Itamar B. Abrass, M.D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation			April 4, 1969		Cedar Hill Crematory		Suitland, Maryland				
24. FUNERAL DIRECTOR Arlington Funeral Home						25a. REC'D BY REGISTRAR DATE APR 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			
3901 N. Fairfax Dr. Arlington, Va.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05555 CERTIFICATE OF DEATH 05549									
1 DECEASED NAME (Type or print) <i>Mr Andrew</i>			First <i>Mr</i> Middle <i>Andrew</i> Last <i>Booke</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>23</i> Year <i>1969</i>			2b. HOUR <i>8:30 P.M.</i>
3. SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Jan 19, 1882</i>		6 AGE (In years last birthday) <i>87</i> YRS.		7 UNDER 1 YEAR MONTHS <i>8</i> DAYS <i>15</i> HOURS <i>15</i> MIN.	
7a BIRTHPLACE (State or foreign country) <i>Sweden</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md			
10 CITY OR TOWN OF DEATH <i>Wheaton Md</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life) <i>Conductor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Transit</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before adm ssion) STATE <i>MD</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>8215 Schrider St. S.S.</i>	
14 FATHER'S NAME <i>Wm. Niles Anderson Booke</i>				15. MOTHER'S MARDEN NAME <i>Marguerite Pearson</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO. <i>529-05-2867</i>		17 INFORMANT <i>Alta S. Booke 8215 Schrider St. (wife)</i>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Probable myocardial infarct</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sec. arteriosclerosis</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>years</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <i>Carcinoma of the prostate</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/28</i> , 1967, to <i>4-23</i> , 1969, that (I) (we) lost the deceased alive on <i>4-23</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Abraham W. Danish</i>				DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <i>4-23-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>ABRAHAM W. DANISH</i>				22e ADDRESS <i>1106 SPAINS ST S.S. 192</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>Apr. 26, 1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Nat'l. Mem. Pk. Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Falls Church, Virginia</i>			
24 FUNERAL DIRECTOR <i>P. J. Smith</i>				ADDRESS <i>8434 Georgia Avenue</i>		25a REC'D BY REGISTRAR <i>APR 29 1969</i>		25b REGISTRAR'S SIGNATURE <i>William E. Pumphrey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05556

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05550

1. DECEASED NAME (Type or print) First Middle Last Harry (None) Borow			2a. DATE OF DEATH Month Day Year April 3 1969		2b. HOUR A 2:22 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 26, 1893		6. AGE (In years last birthday) 76 YRS	7. UNDER YEAR MONTHS DAYS 1 MONTHS 1 DAY
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT - GASOLINE STATION	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE District of Col.		13b. CITY OR TOWN Washington	13c. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 707 Hemlock St., NW	
14. FATHER'S NAME First Middle Last BERYL Borow			15. MOTHER'S MAIDEN NAME First Middle Last HANNAH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 579-01-5942		17. INFORMANT Pt's Chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CORONARY OCCLUSION, MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS 17 YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYPERTENSIVE CARDIOVASCULAR DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from JULY 1953 to APRIL 3, 1969 , that (I) (we) last saw the deceased alive on APRIL 2, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert H. Krichmar		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED April 3 1969	
22d. PHYSICIAN'S NAME (Type) ROBERT H. KRICHMAR MD		22e. ADDRESS 7733 ALASKA AVENUE NW WASHINGTON DC 20012			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-6-69	23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY		23d. LOCATION (City or Town) (County) (State) HYATTSVILLE MARYLAND	
24. FUNERAL DIRECTOR BERNARD DANZANSKY SONS - WASHINGTON - DC		ADDRESS		25a. REC'D BY REGISTRAR APR 10 1969	25b. REGISTRAR'S SIGNATURE William J. Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15
30M REV 1/69

05557										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05551									
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR A									
First Middle Last										Month Day Year										1020 M									
Ann Louise BOWERS										April 28 69																			
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
Female			Caucasian			August 1, 1920			48 YRS.			MONTHS			DAYS			HOURS			MIN.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
Pennsylvania			USA						Montgomery County Md.																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
Bethesda					Naval Hospital					Registered nurse					School board														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET AND NUMBER									
Maryland					Pr. George					Beltsville					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					4100 Kenny St.,									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
Andrew Mikush					Louise Malick Unknown																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address Md.														
Yes 1942-48					220 28 5950					Mr. Allen A. Bowers, 4100 Kenny St.,																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1929 Severe brain edema																													
DUE TO, OR AS A CONSEQUENCE OF Glioblastoma multiforme																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																													
DUE TO, OR AS A CONSEQUENCE OF																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
27 Apr. 69					Glioblastoma multiforme					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					Yes														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
					19																								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (X) (this hospital) attended the deceased from Apr. 25, 1969, to Apr. 28, 1969, that (X) (we) last saw the deceased alive on Apr. 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Calvin B. Early, M.D., PH.D.										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED Apr. 30, 1969														
22d. PHYSICIAN'S NAME (Type) Calvin B. EARLY, MD PHD										22e. ADDRESS Naval Hospital, Bethesda, Md.																			
23a. BURIAL, CREMATION, REMOVAL, OR OTHER					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Burial					5/2/69					Fort Lincoln Crematory					Bladensburg, Pr. Geo. Md.														
24. FUNERAL DIRECTOR E. PUMPHREY Funeral Home										25a. REGD. BY REGISTRAR MAY 5 1969					25b. REGISTRAR'S SIGNATURE														
8434 Georgia Ave., Silver Spring, Md.																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED NAME (Type or print)			First James			Middle Joseph			Last Bradley			2a. DATE OF DEATH Month April			Day 25			Year 1969			2b. HOUR 9:40AM		
3. SEX male			4. RACE Caucasian			5. DATE OF BIRTH 4-9-1888			6. AGE (In years last birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN								
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			Md											
10. CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Lexington Park			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER Box 78			Route 2											
14. FATHER'S NAME First William			Middle Bradley			15. MOTHER'S MAIDEN NAME First Resnick			Middle Resnick			Last Resnick											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT James P Bradley			Address 6120 Old H Rd Chevy Chase Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Proximal Cardiac injury</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized arteriosclerosis</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 4/2, 1969, to 4-25, 1969, that (I) (we) lost saw the deceased alive on 4-24, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>Abraham W. Danish, M.D.</u>			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-25-69														
22d. PHYSICIAN'S NAME (Type) Abraham W. Danish, M.D.			22e. ADDRESS 1106 Spring Street, Silver Spring, Md.																				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE April 28, 1969			23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery			23d. LOCATION (City or Town) (County) (State) Great Mills, St. Mary's, Maryland														
24. FUNERAL DIRECTOR W. Charles Wallingley			ADDRESS Landon Town, Md.			25a. REC'D BY REGISTRAR APR 29 1969			25b. REGISTRAR'S SIGNATURE W. Charles Wallingley														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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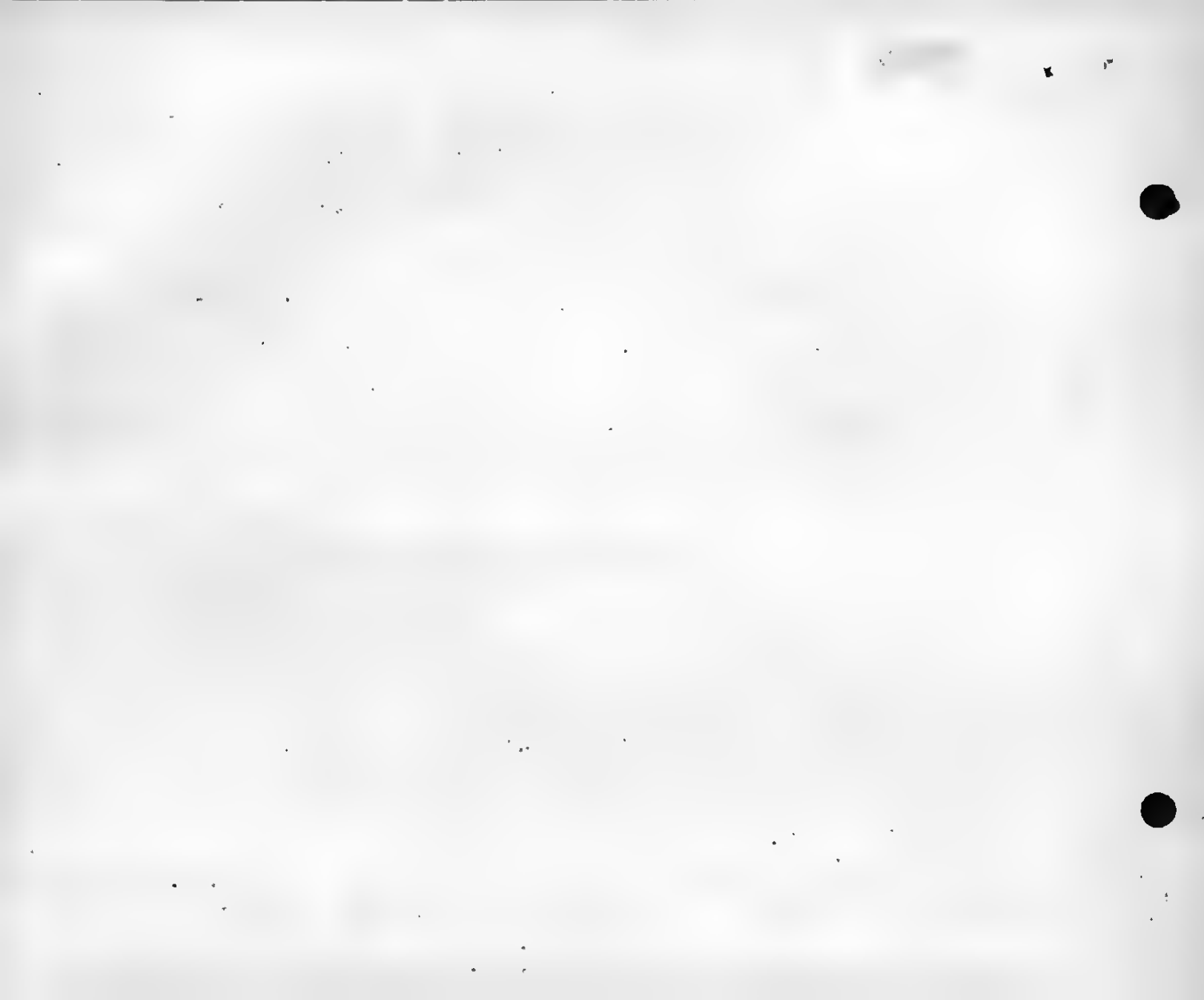
05559

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05553

1. DECEASED-NAME (Type or print) Robert Joseph Brennan			2a. DATE OF DEATH Month APRIL Day 20 Year 1969			2b. HOUR 8:30 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH APRIL 20, 1969		6. AGE (In years last birthday) — YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4204 GALLATIN ST.							
14. FATHER'S NAME First Robert Middle Martin Last Brennan			15. MOTHER'S MAIDEN NAME First June Middle Allison Last Dukes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT mother as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 20, 1969 , to April 21, 1969 , that (I) (we) last saw the deceased alive on April 19, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Murray Paul				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Murray Paul				22e. ADDRESS 1040 University Blvd. E. Langley Park			
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE 2/25/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home				25a. REC'D BY REGISTRAR Rock. Pike Rockville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
25c. DATE APR 28 1969							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-15 M
30M REV

05560										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05554																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First <i>Mary</i> Middle <i>Estelle</i> Last <i>Brown</i>										Month <i>April</i> Day <i>26</i> Year <i>1969</i>										M																			
3. SEX <i>Female</i>										4. RACE <i>White</i>										5. DATE OF BIRTH <i>May 29, 1878</i>										6. AGE (In years last birthday) <i>90</i> YRS.									
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>										7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <i>Montgomery</i> Md									
10. CITY OR TOWN OF DEATH <i>Olney Md.</i>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. John's Hospital</i>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>										12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>									
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>										13b. COUNTY <i>Montgomery</i>										13c. CITY OR TOWN INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>Brookeville</i>										13e. STREET AND NUMBER <i>RD #1-Box 51 AA</i>									
14. FATHER'S NAME First <i>George E</i> Middle <i>Little</i> Last <i>Ann</i>										14. MOTHER'S NAME First <i>Annie</i> Middle <i>Sullivan</i> Last <i>Sullivan</i>										15. ADDRESS <i>Brookeville, Md.</i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <i>no</i> (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. <i>NONE</i>										17. INFORMANT (Son) <i>STANBURY BROWN, RD #1-Box 51 AA</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																																							
IMMEDIATE CAUSE (a) <i>Pulmonary edema</i>																				<i>20 min</i>																			
4109 DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																							
(b) <i>coronary thrombosis</i>																				<i>20 min</i>																			
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
<i>Generalized arteriosclerosis, senile hypotension</i>																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/1/65</i> , 19__, to <i>4/26/69</i> , 19__, that (I) (we) last saw the deceased alive on <i>2/27/69</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE <i>Patrick Jameson</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <i>4/26/69</i>																													
22d. PHYSICIAN'S NAME (Type) <i>Patrick Jameson</i>										22e. ADDRESS <i>11718 Georgia Silver Spring Md</i>																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE <i>Tues., Apr. 29, 1969</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Forest Glen Cemetery</i>										23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Mont., Md.</i>									
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>										24b. ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>										25a. REC'D BY REGISTRAR <i>APP 30 1969</i>										25b. REGISTRAR'S SIGNATURE <i>Patricia J. Jameson</i>									

MEDICAL CERTIFICATE



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			Month	Day	Year	2b. HOUR
Violet Gertrude					Brown	MAY 4 1969			4	16	1969	11:25 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR	
F	W	October 30, 1917	51 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			M.D.			
Crellin, Md.		USA				Montgomery						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Washington San & Hosp			Practical Nurse						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Montgomery			Takoma Pk		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7118 Willow Ave		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
William					Sauers	Fliger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
no			232-26-0934			Mrs. Virginia Stauinger			10222 Falkirk Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pneumonitis and</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>pulmonary emphysema</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>47-X</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			HOUR A.M. P.M.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			Belden R. Reap, M.D.			DEPUTY MEDICAL EXAMINER			APRIL 16, 1969			
			ADDRESS (Street, City, State, and County)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Cremation		4-17-1969		Cedar Hill Crematory		Suitland Maryland						
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Tyson Wheeler Rockville, Maryland				1331 Rockville Pike		APR 18 1969		Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

055562

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05556

1 DECEASED-NAME (Type or print) ELIZABETH CLARICE BRYAN			2c. DATE OF DEATH 4 Month 30 Day 4 Year			2b. HOUR 4:42 M	
3 SEX Female		4 RACE CAUCASION		5. DATE OF BIRTH 3/1/96		6. AGE (in years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON SAN. + HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY LAUREL		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIM 757 YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3716 GREENCASTLE ROAD		14. FATHER'S NAME First CLARENCE Middle BOND Last BOND		15. MOTHER'S MAIDEN NAME First ELIZABETH Middle TURNER Last TURNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Breast - Widespread DUE TO, OR AS A CONSEQUENCE OF (b) Metastases Bone, Liver, Lung DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from May 1964 , to May 1969 , that (I) (we) last saw the deceased alive on May 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph E. Smith, Jr.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr.				22e. ADDRESS Baltimore, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE May 2 - 1969		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore County Md	
24. FUNERAL DIRECTOR Arthur W. H. H. H.		ADDRESS 254 Carroll St. DC		25a. REC'D BY REGISTRAR MAY 1 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05563

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05557

1. DECEASED-NAME (Type or print) First Middle Last Columbus VINCENT BRYANT			2a. DATE OF DEATH Month Day Year April 20 1969			2b. HOUR 6:50 A.M.	
3 SEX male		4 RACE WHITE		5 DATE OF BIRTH 12/8/83		6 AGE (In years last birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RET-CRANE OPERATOR P.A. R.R.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. JS.JAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8718 CAMELOT ST. Apt. 216		14. FATHER'S NAME First Middle Last GEORGETT BRYANT		15. MOTHER'S MAIDEN NAME First Middle Last ESTELLE - ROCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO DIL-03-0984		17 INFORMANT JAMES K. BRYANT - SON - WHEATON, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Generalized arteriosclerosis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute psychosis</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4/19, 1969, to 4/20, 1969, that (I) (we) last saw the deceased alive on 4/19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ronald W. Barr		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/20/69	
22d. PHYSICIAN'S NAME (Type) RONALD W. BARR		22e. ADDRESS 10401 OLD GEORGETOWN RD. BETHESDA					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/23/69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, WASHINGTON, D.C.		ADDRESS 5130 W. SEEN-IN AVE.		25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CLEARED BY MEDICAL EXAMINER (DR. ROGERS COVERING FOR DR. REAP)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05564

05558

1. DECEASED NAME (Type or print) Inez			First Middle Last			2a. DATE OF DEATH Month 4 Day 9 Year 69			2b. HOUR 3:35 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH 9/21/13			6. AGE (in years last birthday) 55 y.s.		
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE New York			13b. COUNTY ?			13c. CITY OR TOWN Oneonta NY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 818 E Jefferson St.			13f. CITY OR TOWN Rock Md			13g. STREET AND NUMBER 818 E Jefferson St.			13h. CITY OR TOWN Rock Md		
14. FATHER'S NAME Raymond D.			First Middle Last			15. MOTHER'S MAIDEN NAME Inez			First Middle Last Le Roy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) none			16b. SOCIAL SECURITY NO. ?			17. INFORMANT son Frank			Address 818 E Jefferson St. Rock Md.		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombophlebitis DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Breast										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day few wks 17 mos	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 1968 to 4/9 , 19 69 , that (I) (we) last saw the deceased alive on 4/9 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Lennard Gold						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4/9/69		
22d. PHYSICIAN'S NAME (Type) G. Lennard Gold						22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit			23b. DATE 4/14/69			23c. NAME OF CEMETERY OR CREMATORY Mt. Mariah			23d. LOCATION (City or Town) (County) (State) Kimble, Pennsylvania		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville						25a. REC'D BY REGISTRAR APR 14 1969			25b. REGISTRAR'S SIGNATURE William J. Gold		
Rockville, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

05565		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05559	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
LEONA		P		BUFFALO	Month Day Year APRIL 9 1969		609 M
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
FEMALE		WHITE		9/10/98		70 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
TENN		USA				MONTGOMERY Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN		Babysitter			
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		MONTGOMERY		Kensington		4221 DRESDEN ST.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
STONEWALL J. PICKARD					FRANCES.		ESCLIE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		410-26-8669		MARTHA JANICE ROONEY - DAUGHTER		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u>							1 month
DUE TO, OR AS A CONSEQUENCE OF (b) <u>uremia</u>							year
DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of uterus</u>							year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-2</u> , 19 <u>69</u> , to <u>4-9</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sarah E. Glover MD</u>				22c. DATE SIGNED <u>4-10-69</u>			
22d. PHYSICIAN'S NAME (Type) Sarah E. Glover, M.D.				22e. ADDRESS <u>1612 CEDAR LANE KENSINGTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		4/14/1969		Gates Cemetery		Gates Tenn.	
24. FUNERAL DIRECTOR TYSON WHEELER FUNERAL HOME Rockville, Md.				25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05566										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05566											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR					
ANNA		M		BYRNE				4-11-69		4		11		1969		3 P M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR	
Female		W		12/05/91		79 YRS		MONTHS		DAYS		APRIL 11		11		1969		3 P M			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH													
Ireland		U.S.A.		WIDOWED		DIVORCED		Montgomery													
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY															
Bethesda		Suburban Hosp.		HOUSEWIFE		AT HOME															
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER													
La.		Rapidis		Pinoville		YES		2100 Expressway													
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last							
James		Owen		McLaughlin				Jane		M. E. Illeney											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS															
NO		NONE		(Daughter)		5423 London Ct. Bethesda, Md.															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4123		Acute Coronary Insufficiency		Arteriosclerotic Heart Disease																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES		NO													
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																	
21d INJURY OCCURRED WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State											
22a. I certify that I took charge of the remains described above held on death resulted from:		Autopsy		Inspection		Inquiry		and in my opinion													
Natural causes		Accident		Suicide		Homicide		Undetermined manner													
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED													
BELDEN R. REAP								APRIL 11, 1969													
EXAMINER'S NAME (Type)		23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)									
BELDEN R. REAP		BURIAL		4-12-69				NEW ORLEANS		LA.											
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE															
W.W. Chambers &		Silver Spring Md.		APR 18 1969		J. Charles Judge															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (III)
45M - 1/69

05567

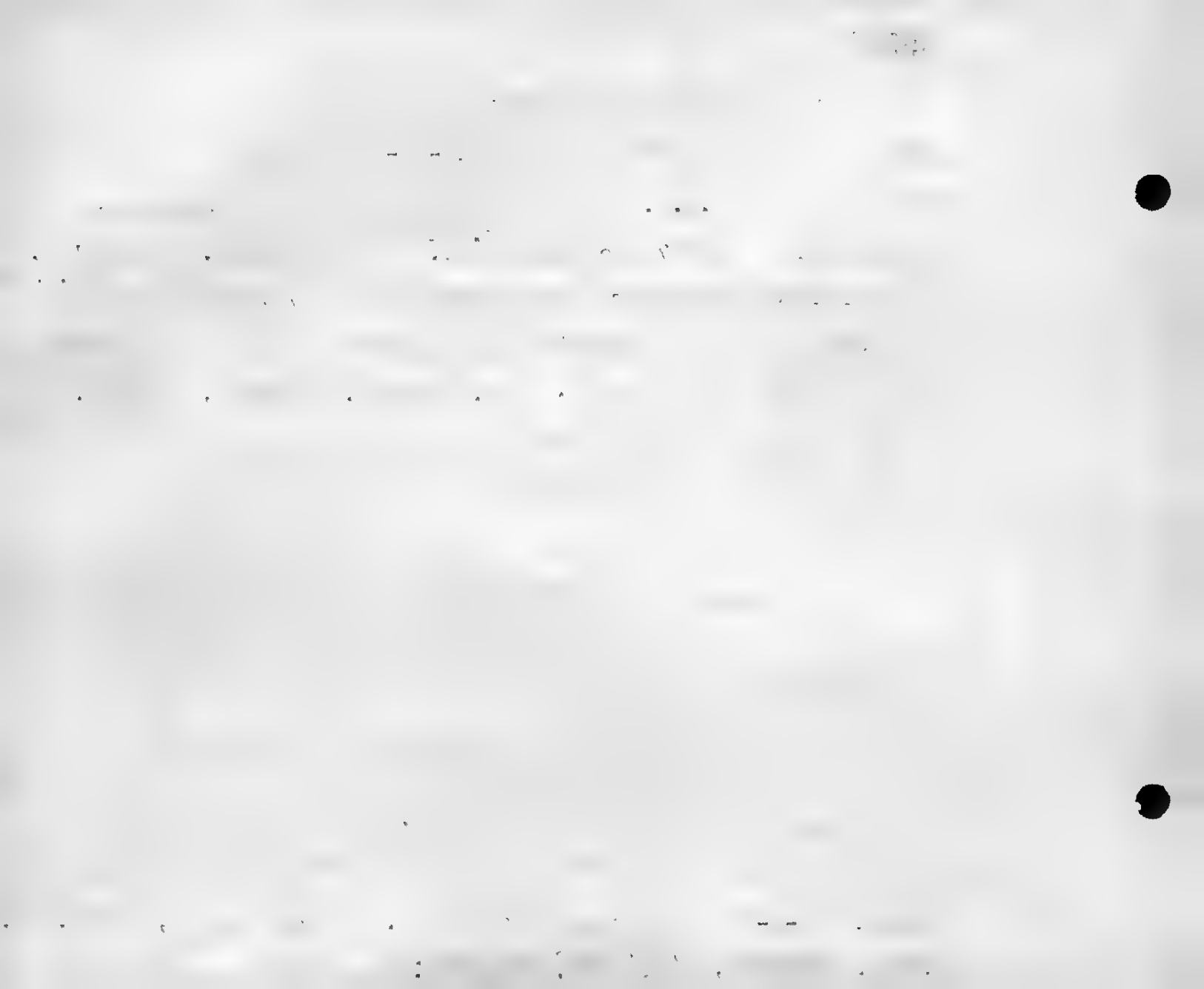
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05561

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH		2b. HOUR	
JAMES ANTHONY CAMPBELL					4 Month 28 Day 69 Year		6 30 A M	
3 SEX	4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Male	White		10-24-99		69 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
New York	U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (Not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Chevy Chase		4757 Chevy Chase Dr.		Office Mngt.		Acc'tg.		
13a USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Montgomery		Chevy Chase				Apt. 219 4757 Chevy Chase Drive
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Felix				Campbell	Hanna			Murphy
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No		***		Not Avail.		Mrs. Helen A. Campbell, above.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malnutrition</u>								6 months
1407 DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) <u>generalized arteriosclerosis</u>								6 months
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>April 8, 1969</u> , to <u>April 28, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 25, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dr Joseph P. Kenrick</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4/28/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>DR JOSEPH P. KENRICK</u>					22e. ADDRESS <u>4450 Wisconsin Ave, Bethesda, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		5-1-69		Gate of Heaven Cem.		Silver Spring, Montg. Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY,				4755 Wisconsin Ave, Bethesda, Maryland		MAY 5 1969 <u>Charles Judge</u>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First EMMA	Middle Florence	Last Carmack	2a. DATE OF DEATH Month April Day 11 Year 1969			2b. HOUR 11:45 AM
3 SEX Female		4 RACE White		5 DATE OF BIRTH October 10, 1879		6 AGE (in years last birthday) 89 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7d. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10019 Kinross Avenue	
14. FATHER'S NAME First Hezekiah Middle Magruder Last Ella Whittington			15. MOTHER'S MIDDLE NAME First Ella Middle Whittington Last Magruder						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-56-4646		17. INFORMANT Emma V. Carmack-10019 Kinross Ave. Pk 5 Chart Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema									2 wks
Conditions, if any, which gave rise to immediate cause (a): DUE TO, OR AS A CONSEQUENCE OF, (b) Congestive heart failure									4 wks
starting the underlying cause last (c) Coronary artery - arteriosclerosis									6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senility Alcohol Intoxication									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to April 11, 1969 , that (I) (we) last saw the deceased alive on April 10, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Philip E. Jones M.D.					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/12/69		
22d. PHYSICIAN'S NAME (Type) Philip E. Jones MD					22e. ADDRESS 800 Pershing Ave. Silver Spring, Md. 20914				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville, Md.			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.					25a. RECEIVED BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]		

05569

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05563

FOR STATE
HEALTH DEPT.

1. DECEASED-NAME (Type or Print)		First Orland		Middle		Last Carra Sr.		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4 18 1969				2b. HOUR M	
3. SEX M	4. RACE W	5. DATE OF BIRTH 12-5-1923		6. AGE (In years last birthday) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 1- 21 1969			2d. HOUR 1:30 PM
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.							
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give address) 7126 Sycamore Ave.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Park Clerk				12b. KIND OF BUSINESS OR INDUSTRY B & O RR			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7126 Sycamore Ave. T.P., Md.					
14. FATHER'S NAME First Middle Last James P. Carra				15. MOTHER'S MAIDEN NAME First Middle Last Anna Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				(If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Orland Carra, Jr. 2699 Dulaney St. Balto 21223					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, lobular, extensive 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED APRIL 21, 1969					
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, Town, or County)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Balto. City Baltimore Md.							
24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Avenue 21229				25a. REC'D BY REGISTRAR DATE APR 25 1969				25b. REGISTRAR'S SIGNATURE James J. [Signature]					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-10. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

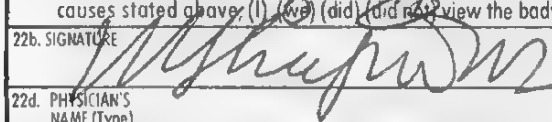

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05570

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05564

1. DECEASED NAME (Type or print) LEONARD FULTON CAUDLE			2a. DATE OF DEATH Month 4 Day 28 Year 69		2b. HOUR 5:05 A.M.
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 12/1/31		6. AGE (In years last birthday) 37-38 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY, Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK DRIVER	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE N.C.		13b. COUNTY MECKLENBURG	13c. CITY OR TOWN CHARLOTTE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9067 ORR STREET
14. FATHER'S NAME First LEONARD C. Middle C. Last CAUDLE (DR.)		15. MOTHER'S MAIDEN NAME First OZELLE Middle POTTS Last CAUDLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (na, or unknown) <input type="checkbox"/> ARMY (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address Mother	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 98 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/26 1969 to 4/28 1969 , that (I) (we) last saw the deceased alive on 4/27 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/28/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-30-69		23c. NAME OF CEMETERY OR CREMATORY Sharon Memorial Park	
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229		23d. LOCATION (City or Town) (County) (State) Charlotte, North Carolina	
VR A15 (4) 30M REV. 1/68		25a. REC'D BY REGISTRAR DATE APR 30 1969		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05571		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05565	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year	
Anna Mae Cecil						April 28 1969	
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
F		W		7-4-79		87 YRS	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Illinois		USA				Montgomery Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville		Potomac Valley Nursing Home		housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
Md.		Montgomery		Gaithersburg		Route 3	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME	
John Fisher						Mary Ryan	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17. INFORMANT		
No					Rodger Flynn, Bethesda, Md.		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebrovascular Accident							1 hour
DUE TO, OR AS A CONSEQUENCE OF							
(b) Arteriosclerotic Cardiovascular Disease							6 years
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
None							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
		HOUR A.M. Month Day Year					
		P.M. 19					
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1963, to April 28, 1969, that (I) (we) last saw the deceased alive on April 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED	
Stephen C. Cromwell MD						April 28, 1969	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Stephen C. Cromwell, MD				615 W. Montgomery, Rockville, Md			
23a BURIAL, CREMATION, REMOVAL, ETC.		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		4-30-69		Glenwood Cemetery		Houston Texas	
24. FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR	
Robert A Pumphrey 7557				Wisconsin Ave Bethesda, Md		DATE MAY 5 1969	
						25b REGISTRAR'S SIGNATURE	
						Charles J. J. J.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

05572

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05566

1. DECEASED NAME (Type or print) First Middle Last <i>Eunice F. Claflin</i>			2a. DATE OF DEATH Month Day Year <i>April 24, 1969</i>			2b. HOUR 43 M	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Aug 6, 1895</i>		6. AGE in years last b. <i>73</i>	
7a. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
3a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Cherry Chase</i>		3d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>Egbert M. Capps</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Florence Chandler</i>		13e. STREET AND NUMBER <i>7303 Rollingwood Rd</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (Type give war or dates of service.)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Dorothy Deitrick</i> Address <i>7303 Rollingwood</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary arteriosclerosis with myocardial infarction.</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>JAN</i> , 19 <i>50</i> , to <i>APRIL</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/22</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>DR LEO DONOVAN</i>				22c. DATE SIGNED <i>4/25/69</i>		22d. PHYSICIAN'S NAME (Type) <i>DR LEO DONOVAN</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>April 28, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek</i>		23d. LOCATION (City or Town) (County) (State) <i>WASHINGTON DC</i>	
24. FUNERAL DIRECTOR <i>JOSEPH LAWLER SONS 5130 WISE AVE NW D.C.</i>				25a. REC'D BY REGISTRAR <i>MAY 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05573

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05567

1. DECEASED NAME (Type or print) DONALD E. CLARK			20. DATE OF DEATH Month April Day 22 Year 1969			2b. HOUR 11:30 M			
3 SEX MALE		4. RACE White		5. DATE OF BIRTH Nov. 21, 1896		6. AGE (In years last birthday) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Half Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired-U.S. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.		13d. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 101-FRANKLIN AVENUE	
14. FATHER'S NAME First Franklin Middle P. Last Clark			15. MOTHER'S MAIDEN NAME First Caroline Middle V. Last Scholl						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> World War 1		16b. SOCIAL SECURITY NO. 213-44-7039		17. INFORMANT Donald R. Clark (Son) Same as #13				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema DUE TO, OR AS A CONSEQUENCE OF with abscess formation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilat. confluent necrotizing bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic pulmonary fibrosis and emphysema								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3-31, 1969 to 4-22, 1969 , that (I) (we) last saw the deceased alive on 4-22, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE JASON GEISER, MD		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 800 VERMONT DRIVE SILVER SPRING		22e. DATE SIGNED 4-22-69			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-24-69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland			
24. FUNERAL DIRECTOR Francis J. Collins				ADDRESS 500 Univ. Blvd. West, Silver Spring, Maryland		25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE William Young	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Mr. Charles Judge

05574										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05568									
1. DECEASED NAME (Type or print) First Middle Last Hester. Flournoy Clarke										2a. DATE OF DEATH Month Day Year 4 13 69										2b. HOUR 3:06 PM									
3. SEX F					4. RACE W					5. DATE OF BIRTH 2-2-84					6. AGE (In years (months) (days) 65 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Va.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md														
10. CITY OR TOWN OF DEATH Takoma Park					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife					12b. KIND OF BUSINESS OR INDUSTRY Home														
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.					13b. COUNTY P.C.					13c. CITY OR TOWN Hyatts					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 2413 Griffin St.									
14. FATHER'S NAME First Middle Last John Clift					15. MOTHER'S MAIDEN NAME First Middle Last Nannie Green																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16b. SOCIAL SECURITY NO					17. INFORMANT Mrs Dorothy white (Dr) Same																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASHD.</u> (b) <u>ASHD.</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minutes 5 years																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
9a. DATE OF OPERATION					9b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 1/16/69, to 4/12/69, that (I) (we) last saw the deceased alive on 4/12/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Hugh Irey</i>					22c. DATE SIGNED 4/13/69					22d. PHYSICIAN'S NAME (Type) HUGH IREY, M.D.					22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE April 16, 1969					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery					23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.														
24. FUNERAL DIRECTOR F. Gasch's Sons					ADDRESS Hyattsville, Md.					25a. REC'D BY REGISTRAR APR 17 1969					25b. REGISTRAR'S SIGNATURE Charles Judge														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap on papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05575

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05569

1. DECEASED-NAME (Type or print) First Middle Last James Edward Cleamons			2a. DATE OF DEATH Month Day Year April 26 1969			2b. HOUR P 4:45 PM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH May, 10, 1901		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farm Worker		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN W. Friendship		13e. STREET AND NUMBER Route 2	
14. FATHER'S NAME First Middle Last Arthur Cleamons			15. MOTHER'S MAIDEN NAME First Middle Last Ida Bacon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Records Address Montgomery General Hospital, Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 HOURS 4 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BRONCHO PNEUMONIA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/16, 1967 to 4/26, 1967 , that (I) (we) last saw the deceased alive on 4/26, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles S. Whitaker, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/20/69	
22d. PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.				22e. ADDRESS Clarksville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-30-69		23c. NAME OF CEMETERY OR CREMATORY St Luke Cemetery		23d. LOCATION (City or Town) (County) (State) Likessville Md.	
24. FUNERAL DIRECTOR Harry W. Hughes				25. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05576 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05570

1. DECEASED NAME (Type or Print)			First ANNA			Middle Marie			Last COBB			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 4 5 1969			2b. HOUR 5:30				
3. SEX F		4. RACE W		5. DATE OF BIRTH 5/18/85		6. AGE (In years last birthday) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 4 5 1969			2d. HOUR 5:30				
7a. BIRTHPLACE (State or foreign country) Oregon				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery County							
10. CITY OR TOWN OF DEATH Silver Spring., Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Montg.				13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 10604 Glenhaven Dr.			
14. FATHER'S NAME First Middle Last Henry Lasfolk						15. MOTHER'S MAIDEN NAME First Middle Last unknown Maryland													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 541-12-6700				17. INFORMANT Silver Spring, Maryland Wesley Cobb-10604 Glenhaven Drive											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Rockville, Maryland				22b. DATE SIGNED April 5, 1969											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Apr. 7, 1969				23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATED ON (City or Town) (County) (State) Rockville, Maryland							
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR DATE APR 11 1969				25b. REGISTRAR'S SIGNATURE William Judge											

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

VR AIE
45M - 1269

05577

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05571

1. DECEASED NAME (Type or print)		First Samuel Middle Francis Last Cole		2a. DATE OF DEATH		Month Day Year		2b. HOUR	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET AND NUMBER		13b. CITY AND STATE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))		19. DATE OF OPERATION		20. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. LOCATION	
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		23a. BLA, CREMATION, REMOVAL (Specify)		23b. DATE	
23a. BLA, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26. DATE		27. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05578

CERTIFICATE OF DEATH

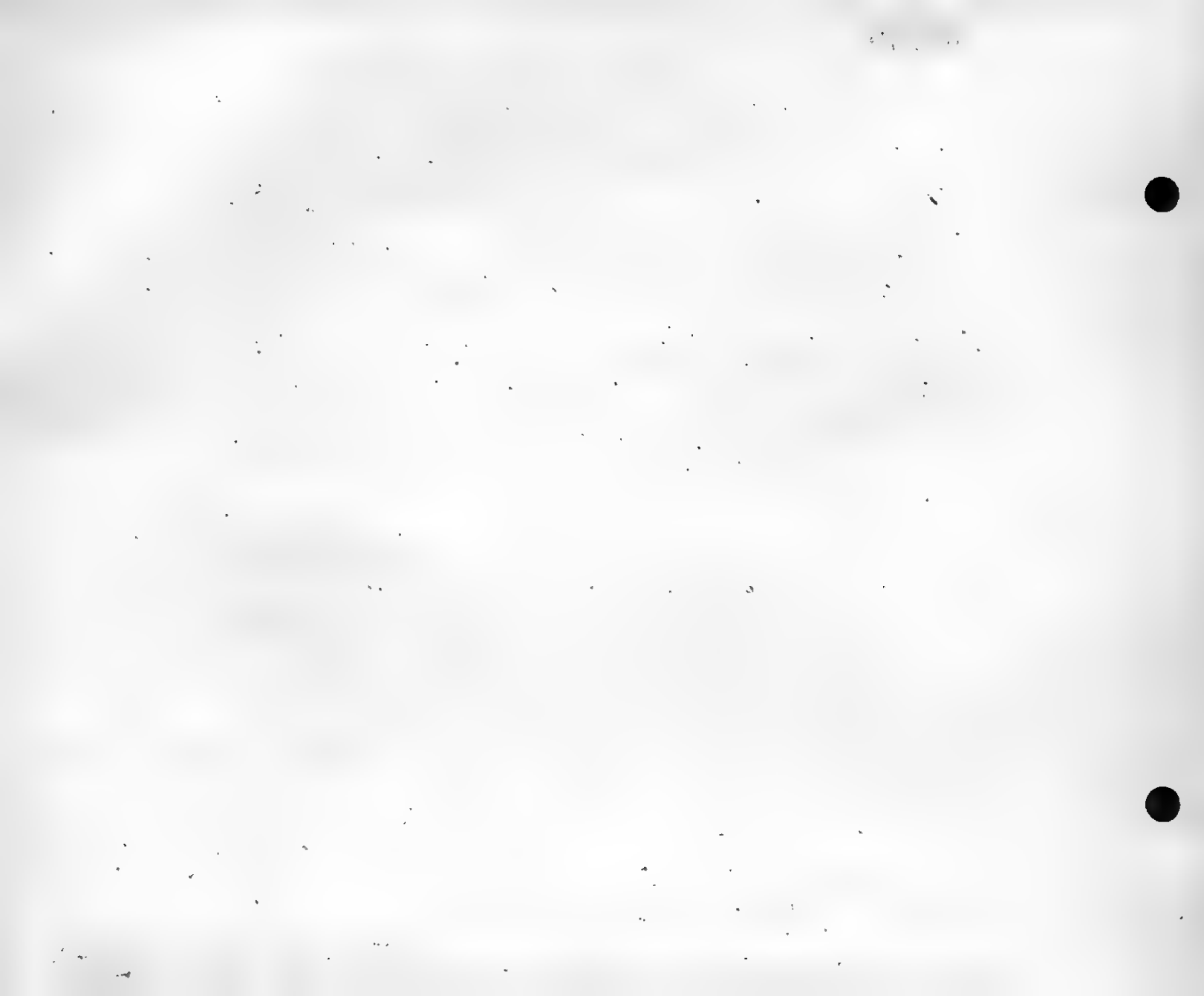
05572

1. DECEASED-NAME (Type or print) <u>Eugene J. Collins</u>			2a. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1969</u>			2b. HOUR <u>12:45 PM</u>			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>1/10/83</u>		6. AGE (in years last birthday) <u>86</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> IF UNDER 24 HRS. HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery Co.</u> Md.			
10. CITY OR TOWN OF DEATH <u>Sil. Spg. Md.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Acting Asst. Dir. (Ret.)</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Mont. Co.</u>		13c. CITY OR TOWN <u>Sil. Spg.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>9702 Woodland Drive</u>	
14. FATHER'S NAME First <u>William</u> Middle <u>Patrick</u> Last <u>Collins</u>			15. MOTHER'S MAIDEN NAME First <u>Ellen</u> Middle <u> </u> Last <u>McDermott</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <u>no</u> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <u>202-44-0748</u>		17. INFORMANT Address <u>Mrs. Naomi T. Collins (wife) Same as #13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 to 4 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> P.M. <u> </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24/69</u> to <u>4/26/69</u> , that (I) (we) last saw the deceased alive on <u>4/26/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John J. Curry M.D.</u>		22c. DATE SIGNED <u>4/26/69</u>		22d. PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY, M.D.</u>		22e. ADDRESS <u>9801 Gaithersburg Road</u>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, BURNING (Specify)		23b. DATE <u>4-29-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Maryland</u>			
24. FUNERAL DIRECTOR <u>Robert J. ...</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>05573</p> <p>Item 1 Filed 4/22/69 kk</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>05573</p> </div> </div>											
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
First Middle Last <i>Raymond Ornell Collins</i>						Month <i>4</i> Day <i>11</i> Year <i>69</i>		<i>2:10 P.M.</i>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<i>Male</i>		<i>White</i>		<i>Nov 5, 1880</i>		<i>88</i> YRS		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
<i>D.C.</i>		<i>U.S.A.</i>				<i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
<i>Silver Spring</i>				<i>9505 North Avenue</i>				<i>Butcher</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
<i>MD</i>				<i>Montgomery</i>		<i>Silver Spring</i>		<i>YES</i>		<i>9505 North Ave.</i>	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
<i>Charles Henry Collins</i>				<i>Emma Elizabeth Maggner</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<i>No</i>				<i>220-46-7934</i>		<i>Mr. R. E. Collins</i>		<i>9505 North Ave. Silver Spring Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>										<i>2 hrs</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Secondary Anemia</i>										<i>3 yrs</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of prostate gland</i>										<i>3 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerosis, Arthritis + Senility</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 20, 1968</i> to <i>April 11, 1969</i> ; that (I) (we) lost the deceased alive on <i>April 4, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Philip E. Jones M.D.</i>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/11/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Philip E. Jones M.D.</i>				22e. ADDRESS <i>800 Rocking Horse Lane Silver Spring Md. 20910</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4/14/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN</i>				23d. LOCATION (City or Town) (County) (State) <i>Bladensburg Md.</i>			
24. FUNERAL DIRECTOR <i>W.W. CHAMBERS Inc.</i>				ADDRESS <i>8635 Q. Ave. Silver Spring</i>		25a. REG. BY REGISTRAR <i>APR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05580

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05574

1 DECEASED-NAME (Type or print) First Middle Last Nellie Jewell Cook			2a. DATE OF DEATH Month Day Year April 5, 1969		2b. HOUR P.M. 2:15
3. SEX Female	4. RACE White	5. DATE OF BIRTH Nov. 29, 1877		6. AGE (In years lost birthday) 91 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		Md
10. CITY OR TOWN OF DEATH Germantown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Marylander Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE District of Columbia	13b. COUNTY Columbia	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3314 Tenneyson St. N.W.	
14. FATHER'S NAME First Middle Last William G. Jewell		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Isabelle Brill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO	17. INFORMANT Address Jerry L. Cook, Damascus, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8/13 , 19 57 , to 4/5 , 19 69 , that (I) (we) lost saw the deceased alive on 4/3 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (view) view the body after death.					
22b. SIGNATURE James P. Kerr M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 4/6/69
22d. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.				22e. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 8, 1969	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR DATE APR 9 1969	
				25b. REGISTRAR'S SIGNATURE William Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115
30M REV. 1-68

05581

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05575

1. DECEASED-NAME (Type or print)		First xxxxxxx P. Michael		Middle xxxxxxx		Last Cook		2a. DATE OF DEATH			2b. HOUR		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6/13/98		6. AGE (In years last birthday) 70 YRS.		7. MONTH April		8. DAY 27		9. YEAR 69	
7a. BIRTHPLACE (State or foreign country) Wash DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgom. Co.							
10. CITY OR TOWN OF DEATH Sil. Spg Md.		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LAWYER		12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Mont. Co.		13c. CITY OR TOWN Sil. Spg Md		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8601 Marchant Road					
14. FATHER'S NAME		First Michael		Middle J.		Last Cook		15. MOTHER'S MAIDEN NAME		First Katherine		Middle Cioherty	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		World I		16b. SOCIAL SECURITY NO. 577-09-0790		17. INFORMANT Mrs. P. Michael Cook		Address Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Branchogenic carcinoma of Oropharynx</u> WKS DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic to 1) Liver</u> WKS (c) <u>2) Stomach + Bladder</u> WKS <u>3) Metastatic + lymphatic</u> WKS Conditions if any, which govern rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> , 19 <u>69</u> , to <u>4/27</u> , 19 <u>69</u> , that (I) (we) lost the deceased on <u>4/26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death													
22b. SIGNATURE <u>Albert H. Grollman</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/27/69</u>							
22d. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>		22e. ADDRESS <u>1106 SPRING ST. SILVER SPRING</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-30-69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Maryland							
24. FUNERAL DIRECTOR <u>James J. Collins</u>		ADDRESS <u>500 University Blvd W Silver Spring Md</u>		25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

• • • • • XXXXX • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05582 CERTIFICATE OF DEATH 05576									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Jennie (NMN) Cooper						April 23 1969			4:50 M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
Female	White		January 14, 1886			83 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Russia		America				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Washington Sanitarium			Owner-Hardware and furniture			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Washington D.C.			D.C.				4700 Connecticut avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Isaac Miller			Rose Sachs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
no					Patient's chart				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>									<u>5 HOURS</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>									<u>6 MONTHS</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HYPERTENSION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>July, 1957</u> , to <u>23 April 1969</u> , that (I) (we) last saw the deceased alive on <u>22 April 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Robert L. Krichmar</u>		<u>23 April 1969</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<u>ROBERT L. KRICHMAR</u>		<u>7733 ALASKA AVE NE WASH DC 20012</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)	(State)
<u>Burial</u>		<u>4/25/69</u>		<u>Adas Israel Cong. Cem.</u>		<u>Wash., D. C.</u>			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Bernard Danzansky and Sons</u>				<u>APR 28 1969</u>		<u>Charles Judge</u>			
<u>3501 14th St. N.W., Wash., D.C.</u>									



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND										05583		05577			
1 DECEASED NAME (Type or Print) WILLIAM W. COPELAND										2a. DATE KNOWN OF DEATH 4-10-69		2b. HOUR 1:45			
3 SEX M		4 RACE NEGRO		5. DATE OF BIRTH 5-2-1884		6. AGE (In years last birthday) 84		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 4-10-69		2d. HOUR 1:45			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH DICKERSON				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Big Woods Rd 3				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD				13b. COUNTY Montgomery				13c. CITY OR TOWN Dickerson		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Daniel Middle Copeland Last				15. MOTHER'S MAIDEN NAME First Mary Middle Dorsey Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication DUE TO, OR AS A CONSEQUENCE OF (b) and conflagration burns of 90% of body DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 12:45 PM 4-10-69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased in house which caught fire (cause unknown) and died of carbon monoxide poisoning							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. Dickerson Montg. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE SIGNED April 10, 1969					
ACTUAL SIGNATURE Belden R. Keap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED April 10, 1969							
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City or Town, State) Rockville, Md.							
23a. B.P.A. CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 4/13/69				23c. NAME OF CEMETERY OR CREMATORY Jerusalem Cemetery				23d. LOCATION (City or Town) (County) (State) Foolesville, Montg. Md.			
24. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville, Md.				25a. READ BY REGISTRAR APR 17 1969				25b. REGISTRAR'S SIGNATURE Thomas, Judge			



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05584

CERTIFICATE OF DEATH

OF HEALTH—BALTIMORE, 18

Reg. Dist. No. 05578

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POTOMAC</u>		c. LENGTH OF STAY IN 1b <u>84 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POTOMAC</u>	
		d. STREET ADDRESS <u>9119 BRADLEY BLVD.</u>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>COUNSELMAN</u> Middle <u>—</u> Last		4. DATE OF DEATH <u>APRIL 11</u> Month <u>11</u> Day <u>1969</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 12, 1884</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GREENSKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOLF CLUB</u>	
11. BIRTHPLACE (State or foreign country) <u>BETHESDA MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM G. COUNSELMAN</u>		14. MOTHER'S MAIDEN NAME <u>JULIA A. OFFUTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-2701</u>	
17. INFORMANT <u>MRS. PAULINE CLARK</u> Address <u>5300 WESTBARD BETHESDA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STROKE (APOPLEXY)</u> <u>4369</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE BRONCHITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 10</u> , 19 <u>69</u> , to <u>APRIL 11</u> , 19 <u>69</u> , that I last saw the deceased alive on <u>APRIL 10</u> , 19 <u>69</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vincent J. DiFrancesco</u> M.D.		ADDRESS (Street, city or town, state) <u>6601 GREENTREE ROAD BETHESDA, MD.</u> DATE SIGNED <u>APRIL 11, 1969</u>	
PHYSICIAN'S NAME (Type) <u>VINCENT J. DIFRANCESCO</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/69</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Potomac Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>APR 15 1969</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1

2

1

MD

MARYLAND STATE DEPARTMENT OF HEALTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 103
45M 103

05585

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05573

1. DECEASED NAME (Type or print) First Middle Last ROSIE BELLE COUNSELMAN			2a. DATE OF DEATH Month Day Year 7 29 69			2b. HOUR MIN 12:00 PM				
3. SEX F		4. RACE CAUCASIAN		5. DATE OF BIRTH 12/28/88		6. AGE (In years last birthday) MONTHS DAYS 80 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GROSVENOR NURSE HOME 5121 BRADLEY BL. BETHESDA			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut admission) STATE MD.			13b. COUNTY MONT.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 9119 BRADLEY BLVD	
14. FATHER'S NAME First Middle Last MILTON FRANCIS EMBREY			15. MOTHER'S MAIDEN NAME First Middle Last MARY ELIZABETH CAYWOOD							
16a. WAS DECEASED EVER Yes, no, or unknown		16b. IN U.S. ARMED FORCES? (If yes give year or dates of service)		16c. SOCIAL SECURITY NO.		17. INFORMANT Address PAULINE C. CLARK (DAUGHTER)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS 3 YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NOT CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 1967 to APRIL 29, 1969 , that (I) (we) saw the deceased alive on APRIL 29, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Vincent J. Di Francesco, MD.					DEGREE MD.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED April 29, 1969	
22d. PHYSICIAN'S NAME (Type) VINCENT J. DI FRANCESCO					22e. ADDRESS 6601 GREENTREE RD. BETHESDA, MD.					
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 5/2/69		23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cemetery			23d. LOCATION (City or Town) (County) (State) Potomac, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Fun. Home Rockville MD					1331 ADDRESS Rockville MD		25a. REC'D BY REGISTRAR May 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 45M
JUN 69

05586

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05580

1 DECEASED-NAME (Type or print) Charles Victor Coupard			2a DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1969</u>			2b HOUR <u>5:25</u> AM	
3 SEX <u>MALE</u>		4 RACE <u>WHITE</u>		5. DATE OF BIRTH <u>11/5/85</u>		6. AGE (In years last birthday) <u>84</u> YRS.	
7a BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>MONTGOMERY</u> Md	
10 CITY OR TOWN OF DEATH <u>BETHES DA</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>SUBURBAN</u>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u></u>		12b. KIND OF BUSINESS OR INDUSTRY <u></u>	
13a USLA RES DENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c CITY OR TOWN <u>ROCKVILLE</u>		13e STREET AND NUMBER <u>719 MONROE St</u>	
14. FATHER'S NAME First Middle Last <u>CHARLES</u> <u>C</u> <u>C</u>		15 MOTHER'S MAIDEN NAME First Middle Last <u>MARY</u> <u>T</u> <u></u>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <u></u>		17 INFORMANT <u>CHARLES Coupard - son</u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycobacterium Infection</u> <u>41</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>?</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pneumonia, pleural effusion, curculosis</u>							
19a. DATE OF OPERATION <u></u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u></u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) <u></u>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u></u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u></u>			
22a I certify that (I) (this hospital) attended the deceased from <u>19 APRIL, 19 69</u> to <u>25 APR, 19 69</u> , that (I) (we) last saw the deceased alive on <u>24 apr</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE <u>John S. Saia</u>		DEGREE <u>MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-25-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>John S. Saia</u>		22e. ADDRESS <u>809 Veirsmill Rd. Rockville, Md.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 28, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, MARYLAND</u>	
24 FUNERAL DIRECTOR <u>Joseph GAWLERS SONS</u>		ADDRESS <u>5730 WISC. AVE. N.W. D.C.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

05587

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05581

1. DECEASED-NAME (Type or print) <u>Alexander</u> First <u>None</u> Middle <u>Cowan</u> Last			2a. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1969</u>			2b. HOUR <u>3:05</u> P.M.	
3. SEX <u>Male</u>		4. RACE <u>Cauc.</u>		5. DATE OF BIRTH <u>2/23/15</u>		6. AGE (In years last birthday) <u>53</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Scotland</u>		7b. CIT. ZEN OF WHAT COUNTRY? <u>American</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>USA / Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASH. SAN & Hosp</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Mechanic</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>WASH. Sub. San. Commission</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>Mont.</u>		13c. CITY OR TOWN <u>Riverdale</u>		13d. INS. OF CITY L.M.T.S.P. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>5906 Longfellow St. E.</u>							
14. FATHER'S NAME First <u>David</u> Middle <u>None</u> Last <u>Cowan</u>			15. MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>None</u> Last <u>Thompson</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>212-30-7924</u>		17. INFORMANT <u>PL's chart</u> Address <u>WSH - 7600 CARROLL Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Colioblastoma (cancer) left parietal lobe</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <u>3/3/69</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Neoplasm</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <u>Feb 21, 1969</u> , to <u>Apr 6, 1969</u> , that (1) (we) last saw the deceased alive on <u>Apr 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (4) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>Arthur D. Itofsky</u> MD		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>Apr 7, 1969</u>	
22d. PHYSICIAN'S NAME (Type) <u>Arthur D. Itofsky</u> MD		22e. ADDRESS <u>1015 Spring St. S.S. 20910.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 9, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				25a. REC'D BY REG. STRAR DATE <u>APR 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

05588

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05582

1. DECEASED-NAME (Type or print)		First HORACE	Middle HENRY	Lost CRAIG	2a. DATE OF DEATH Month Day Year April 29 1969		12b. HOUR 12:18 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH January 4, 1921		6. AGE (In years last birthday) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington, D.C. USA		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electronics Inspector		12b. KIND OF BUSINESS OR INDUSTRY Civilian Ser Commiss				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY P. Marys		13c. CITY OR TOWN Lexington Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 305 Kearsarge Place		
14. FATHER'S NAME First Middle Lost Guy F. CRAIG		15. MOTHER'S MAIDEN NAME First Middle Lost Lillian (Unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes WWII, Korea					16b. SOCIAL SECURITY NO 140-05-8914	
17. INFORMANT Wife: Mrs. Jean E. Craig		17. ADDRESS 305 Keasarge Place, Lexington Park, Md.		17. ADDRESS 20653						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1729 GLIOBLASTOMA MULTIFORME WITH SECONDARY BILATERAL DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from March 4, 1969, to April 29, 1969, that (X) (we) lost saw the deceased alive on April 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE William L. Brannon Jr., M.D.		DEGREE CDR MC USN		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 April 69				
22d. PHYSICIAN'S NAME (Type) WILLIAM L. BRANNON JR.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND								
23a. BURIAL, CREMATION, OTHER (Specify)		23b. DATE May 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington Virginia				
24. FUNERAL DIRECTOR HOME,		24. ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05589

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05583

1. DECEASED-NAME (Type or print) Damon			First E. Middle CUMMINGS Last			2a. DATE OF DEATH April Month 20 Day 1969 Year			2b. HOUR 1017PM						
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH Apr. 16, 1885			6. AGE (In years last birthday) 84 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Minnesota			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.			13b. COUNTY			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2329 Porter St., N. W.			
14. FATHER'S NAME Charles			First Arthur Middle Cummings Last			15. MOTHER'S M A D E N NAME Ada			First Florence Middle Earhart Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 1906-46			17. INFORMANT Damon E. Cummings, 27 Auburn St., Woburn, Mas									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State 9:00 A.M.									
22a. I certify that (this hospital) attended the deceased from Apr. 20 , 19 69 , to Apr 20 , 19 69 , that (I) (we) last saw the deceased alive on Apr. 20 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE John E. Hornbaker Jr			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 22 April 1969						
22d. PHYSICIAN'S NAME (Type) J. H. HORNBAKER, JR, M.D.			22e. ADDRESS Naval Hospital, Bethesda, Md.												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4/28/69			23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			23d. LOCATION (City or Town) (County) (State) Arlington Va.						
24. FUNERAL DIRECTOR Jos. Gawler's Sons ADDRESS 5130 Wisconsin Ave., N.W. Washington, D. C.						25a. REC'D BY REGISTRAR APR 25 1969			25b. REGISTRAR'S SIGNATURE Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (Pages 1 and 2), director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05584									
05590									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JESSE			MARTON DAY			Month Day Year 4 12 69			2:28 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Male		White		11-20-99		69 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		United States				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Olney			Montgomery General Hospital			Frm worker			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Montgomery		Derwood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6905 Garrett Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last George W. Day			First Middle Last Joanna Reed						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT				
no			220-01-0288		Admission Redd, Montgomery Gen. Hospital, Olney				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2da</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis - Terminal</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
3/31/69		cholesterol embolism		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
22a. I certify that (I) (this hospital) attended the deceased from <u>3/24/69</u> to <u>4/12/69</u> , that (I) (we) last saw the deceased alive on <u>4/12/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>Ernest C. Gartner</u>		4/14/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		Rockville - Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4-15th 69		Forest Oak		Gaithersburg/		Montg. Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Ernest C. Gartner</u>		APR 17 1969		<u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05591

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05585

1. DECEASED-NAME (Type or print) <i>Latv First Middle Last Mary</i>				2a. DATE OF DEATH 4 Month 30 Day 69 Year				2b. HOUR 12 P.M.																			
3. SEX <i>Female</i>				4. RACE <i>White</i>				5. DATE OF BIRTH 9-15-83				6. AGE (In years last birthday) 85 YRS.				IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Montgomery</i> Md															
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>															
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>md</i>				13b. COUNTY <i>mont. Chevy Chase</i>				13c. CITY OR TOWN <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>				13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>				13e. STREET AND NUMBER <i>3504 Lucretia Lane</i>											
14. FATHER'S NAME <i>John First Middle Last Kidevell</i>				15. MOTHER'S MAIDEN NAME <i>Mary Virginia Soper</i>																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>217-52-7220</i>				17. INFORMANT <i>Leo Ray Turner Home, Ch. Ch. Md</i>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gastro Intestinal Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Myocardial Ischemia @ largest Heart Failure</i>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/14</i> , 1969, to <i>4/30</i> , 1969, that (I) (we) last saw the deceased alive on <i>4/30</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE <i>R. J. BRENNAN MD</i>																DEGREE <i>MD</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <i>4/30/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>R. J. BRENNAN</i>																22e. ADDRESS <i>Bethesda, Md</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>5-3-69</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Rockville Mont Md</i>															
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>																25a. REC'D BY REGISTRAR DATE <i>MAY 7 1969</i>				25b. REGISTRAR'S SIGNATURE <i>William Judge</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05592

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05586

1. DECEASED-NAME (Type or print) Mattie		First Rebecca		Middle Day		Last		2a. DATE OF DEATH April 20 1969		2b. HOUR 5 AM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH 10-23-1890		6 AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS 6 DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery					
1d. CITY OR TOWN OF DEATH Gaithersburg		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY No.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Res. before admission) Maryland		13b. CITY OR TOWN Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER --			
14 FATHER'S NAME Henry D. Measell		First Measell		Middle		Last		15 MOTHER'S MAIDEN NAME Susan R. Staley		First Staley	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		(1 Yes give war or dates of service)		16b SOCIAL SECURITY NO. 577-42-8907-J1		17 INFORMANT Mamie Beffner		Address 6012 Milfan Dr S. E. 20027			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks	
DUE TO, OR AS A CONSEQUENCE OF (b) Dissecting aortic aneurysm										10 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING ETC)		21f. LOCATION Street, or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4/15/69 , 19 69 , to 4/20/69 , 19 69 , that (I) (we) last saw the deceased alive on 4/15/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Henry C. Scruggs		22c DATE SIGNED 4/20/69		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (Type) H. C. Scruggs, M. D.		22e ADDRESS 5413 Cedar Lane Bethesda Md									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4-23-1969		23c. NAME OF CEMETERY OR CREMATORY Forestville Methodist		23d LOCATION (City or Town) Forestville		(County) Maryland		(State)	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home						25a REC'D BY REGISTRAR APR 24 1969		25b REGISTRAR'S SIGNATURE Charles J. George			
4308 Suitland Rd Suitland Maryland											

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05593		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		05587					
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Robert Francis Dearduff			Robert	Francis	Dearduff	April 22 1969		12:08 A.M.			
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR			
Male		White		June 28, 1908		60 YRS.		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH		10. UNDER 24 HRS.			
New York		America		WIDOWED		Montgomery		YEARS			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13. UNDER 24 HRS.			
Takoma Park		Washington Sanitarium		Manager-Kolb Electric Co.				YEARS			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Montgomery		Takoma Park		YES NO		7125 Carroll Avenue			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Frank S. Dearduff			Frank	S.	Dearduff	Teresa Barron			Teresa	Barron	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			218 03 5570			Patient's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) Acute Anterior Myocardial Infarction								4 days			
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis								years			
DUE TO, OR AS A CONSEQUENCE OF (c) Cigarette AV block + RBBB								acute			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES NO						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While Not while at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from APR. 19, 1969, to APR. 22, 1969, that (I) (we) last saw the deceased alive on APRIL 21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE		ATTENDING PHYS		22c. DATE SIGNED		
CHARLES H. WOLOITON							MED. DIRECTOR		4-22-69		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS		22f. REGISTRAR'S SIGNATURE				
CHARLES H. WOLOITON					831 University Blvd. E., Silver Spring, Md.		Charles J. Judge				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. REGISTRAR'S SIGNATURE			
Burial		April 24 1969		Folk Lincoln Cemetery		Calver Manor, Md.		Charles J. Judge			
24. FUNERAL DIRECTOR		24a. ADDRESS		24b. REC'D BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE			
Arthur Walters		By DAY 25 Carroll St. Wash. D.C.		APR 24 1969		Charles J. Judge		Charles J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M 1/69

05594

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05588

1 DECEASED NAME (Type or print) <i>Mrs Lottie Delahanty</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>17</i> Year <i>69</i>			2b. HOUR <i>9:30 P M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>4-9-91</i>		6. AGE (In years last birthday) <i>78</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <i>Cranbury N.J.</i>	7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md			
10 CITY OR TOWN OF DEATH <i>Wheaton</i>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Prison Matron</i>	12b KIND OF BUSINESS OR INDUSTRY <i>Trenton N.J.</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Trenton N.J.</i>	13b COUNTY <i>Mercer</i>	13c CITY OR TOWN <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>	13e STREET AND NUMBER			
14 FATHER'S NAME First Middle Last <i>XXXXXXXXXXXX James L. Courtney</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>XXXXXXXXXXXX Mary A. Haggerty</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <i>138-30-8463</i>		17. INFORMANT <i>Mr James M. Delahanty Wash DC</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA</i> <i>4:56 P</i> DUE TO, OR AS A CONSEQUENCE OF Circumstances, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Multiple myeloma.</i>						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No City or Town County State		
22a I certify that (I) (this hospital) attended the deceased from <i>1/14</i> , 19 <i>69</i> , to <i>4/17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/17</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <i>Myron L. Lenkin</i> MD DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>4/17/69</i>
22d. PHYSICIAN'S NAME (Type) <i>Myron L. Lenkin</i>				22e. ADDRESS		
23a BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b DATE <i>April 21, 1969</i>	23c NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Trenton, New Jersey</i>	
24 FUNERAL DIRECTOR <i>Warner C. Pumphrey, Inc.</i>		25a ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c REGISTRAR'S DATE <i>APR 22 1969</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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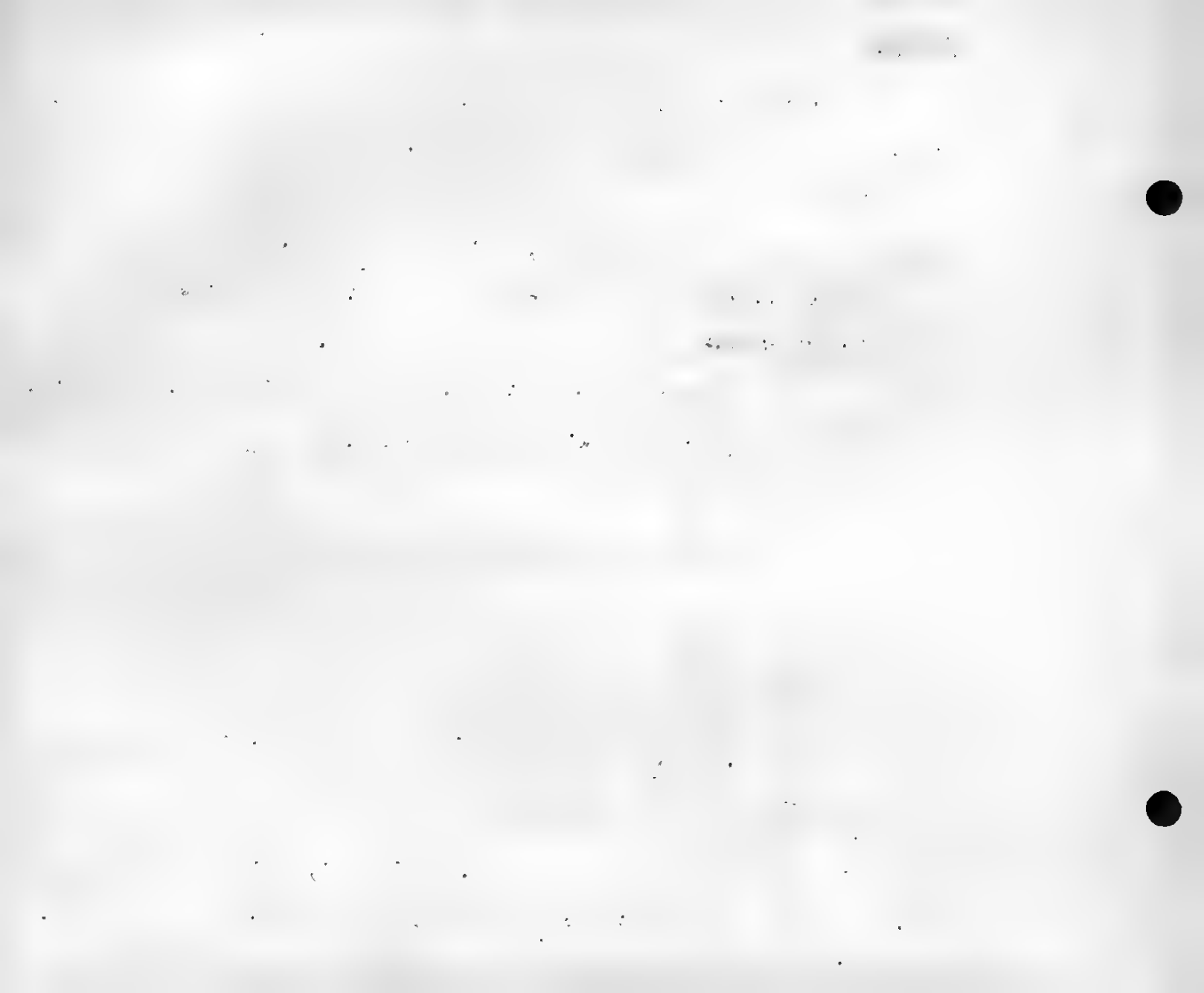
VA 115 (4)
45M - 1/69

05595		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05594					
1 DECEASED-NAME (Type or print) <u>Thomas V. Delaney</u>						2a DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1969</u>			2b. HOUR <u>5:52 PM</u>		
3 SEX <u>MALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>7-1-05</u> <u>7-1-05</u>		6. AGE (In years last birthday) <u>63</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md					
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired</u>		12b KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>D.C.</u>		13b COUNTY <u>Washington</u>		13c CITY OR TOWN <u>Washington</u>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <u>722 Somerset Place N.W.</u>			
14 FATHER'S NAME First <u>John</u> Middle <u>A</u> Last <u>Delaney</u>		15 MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>A.</u> Last <u>Auntyer</u>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <u>578-01-5611</u>		17 INFORMANT Address <u>MARY E. TUTT - 3620 13th St N.E.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subdural hemorrhage, spontaneous</u> <u>430Y</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured berry aneurysm, left middle cerebral</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>10 hours</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Subacute and chronic pancreatitis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , to <u>4-6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-6</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Sarah E. Glover M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-7-69</u>					
22d. PHYSICIAN'S NAME (Type) <u>Sarah E. Glover, M.D.</u>		22e. ADDRESS <u>10128 CEDAR LAKE HILLSIDE TOWN, MD</u>									
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>4-10-69</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>					
24. FUNERAL DIRECTOR <u>Francis J. Collins</u>		ADDRESS <u>2111 Community Blvd. N.W. Spring</u>		25a REC'D BY REGISTRAR <u>APR 15 1969</u>		25b. PHYSICIAN'S SIGNATURE <u>[Signature]</u>					

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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
05596 CERTIFICATE OF DEATH 05591												
1. DECEASED NAME (Type or print) JOSEPHINE KLOBER DELAPA						2a. DATE OF DEATH Month APRIL Day 18 Year 69			2b. HOUR 6:09 MIN A			
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH 28 JUNE 1921			6. AGE (In years last birthday) 47 YRS.		7. UNDER 1 YEAR MONTHS DAYS 		8. UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) NEW Jersey			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY Md			
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, BETH MD			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND 13b. COUNTY Montgomery			13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4010 ADAMS DRIVE					
14. FATHER'S NAME First CHARLES Middle KLOBER Last Klober						15. MOTHER'S MAIDEN NAME First Minna Middle Last Ruland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) NO (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 154-14-8134			17. INFORMANT Address FIORE S. DELAPA 4010 ADAMS DR. WHEATON MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA OF COLON WITH METASTASIS 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11 APRIL , 19 69 , to 18 APRIL , 19 69 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 APRIL , 19 69 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did (did not) view the body after death.												
22b. SIGNATURE JR Fletcher M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 18 APRIL 1969			
22d. PHYSICIAN'S NAME (Type) JOHN R. FLETCHER MD						22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 4-21-69			23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT CEMETARY			23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.			
24. FUNERAL DIRECTOR Collins COLLINS FUNERAL HOME 500 UNIVERSITY BLVD						25a. REC'D BY REGISTRAR DATE APR 23 1969			25b. REGISTRAR'S SIGNATURE Charles Judge			



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VR AIS
45M - 1/69

05597

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05592

1. DECEASED-NAME (Type or print) CHARLES RAYMOND DENNIS			First Middle Lost			2a. DATE OF DEATH Month Day Year April 17, 1969			2b. HOUR 9:23 PM					
3. SEX Male			4. RACE White			5. DATE OF BIRTH August 31, 1903			6. AGE (In years lost birthday) 65 YRS.					
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of work pg life, even if ret red) Telephone Company			12b. KIND OF BUSINESS OR INDUSTRY C & P Tel Co					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY P.G.			13c. CITY OR TOWN Takoma Pk.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1116 Jackson Ave Takoma Park, Maryland		
14. FATHER'S NAME Charles Dennis			First Middle Lost			15. MOTHER'S MA DEN NAME Cleora Shockley			First Middle Lost					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None			16b. SOCIAL SECURITY NO. 577-01-0051			17. INFORMANT Mrs. Gertrude Dennis			Address ---- Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from June 25, 1968 , to April 17, 1969 , that (I) (we) last saw the deceased alive on April 8, 1969 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Boris Rabkin			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED April 18, 1969					
22d. PHYSICIAN'S NAME (Type) Boris Rabkin, M.D.			22e. ADDRESS 1019 Univ Blvd E											
23a. BURIAL CREMATION APR 21, 1969			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland					
24. FUNERAL HOME OR OTHER ADDRESS Warner E. Pumphrey, Inc. Silver Spring, Md.						25a. RECEIVED BY REGISTRAR APR 22 1969			25b. REGISTRAR'S SIGNATURE [Signature]					

FOR STATE HEALTH DEPT.

05598

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First KATHLEEN		Middle MACNEAL		Last DENT		2a. DATE KNOWN OF EST- DEATH MATED <input checked="" type="checkbox"/> 4 11 1969		2b. HOUR 6:55 P.M.	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 7/4/66		6 AGE (in years last birthday) 22 YRS		IF UNDER 1 YEAR MONTHS OAYS		F UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month 4 Day 11 Year 19 69	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 13024 Ingleside Drive			
14. FATHER'S NAME First Middle Last Theodore H. Dent, Jr.				15. MOTHER'S MAIDEN NAME First Middle Last Mary -- Powars							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT ADDRESS Theodore Dent, Sr., Chevy Chase, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Extreme Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) including Fractured Skull. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4:11 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Child released brake, fell out of auto and was run over							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No City or Town County State 13024 Ingleside Dr. Beltsville Prince Geo. Md							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Belden R. Reap M.D. BELDEN R. REAP M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town, or County)		22b. DATE SIGNED April 11, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland			
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Washington, D.C. 20016				5130 Wisconsin Ave., N.W.		25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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05599

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05594

1. DECEASED NAME (Type or Print) ERWIN			First ERWIN			Middle C			Last DIETLE			2a. DATE KNOWN OF DEATH EST <input checked="" type="checkbox"/> Month 4 Day 30 Year 1969			2b. HOUR 7:09						
3 SEX Male		4 RACE White		5 DATE OF BIRTH 11/5/17		6 AGE (In years last birthday) 51 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 		2c. DATE PRONOUNCED DEAD Month 4 Day 30 Year 1969			2d. HOUR 7:09						
7a. BIRTHPLACE (State or foreign country) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery									
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) salesman				12b. KIND OF BUSINESS OR INDUSTRY Dept. Store									
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN S.S.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10012 Portland Rd. S.S. Md							
14. FATHER'S NAME First Richard Middle J Last Dietle						15. MOTHER'S MAIDEN NAME First Matilda Middle (unknown) Last 															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) yes				17. INFORMANT wife Ruth						ADDRESS 10012 Portland Rd. S.S. Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery Heart Disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) 																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. 				City or Town 				County 				State 	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Belden R. Reap				EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 4/30/1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE May 2, 1969				23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville Maryland									
24. FUNERAL DIRECTOR Harner E. Pumphrey, Inc. 8434-Ga. Ave. Silver Spring				ADDRESS Maryland				25a. REC'D BY REGISTRAR MAY 5 1969				25b. REGISTRAR'S SIGNATURE Charles Judge									

0.75

0.75

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expected within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05600		CERTIFICATE OF DEATH				05590			
1. DECEASED NAME (Type or print) First Middle Last FRANK ELLSWORTH DIETZ					2a. DATE OF DEATH Month Day Year 4 17 1969			2b. HOUR 9:20 PM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 1/9/1895		6. AGE (In years last birthday) 74 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON GAR. SANT.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN BETH.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5906 WALTON ROAD	
14. FATHER'S NAME First Middle Last John P. DIETZ		15. MOTHER'S MAIDEN NAME First Middle CLARA F. (Schlegel) Schlegel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) YES U.S. I		16b. SOCIAL SECURITY NO -		17. INFORMANT ANNIE B. DIETZ		Address 5906 WALTON RD. BETHESDA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism 4417 DUE TO, OR AS A CONSEQUENCE OF (b) Thrombophlebitis DUE TO, OR AS A CONSEQUENCE OF (c) Arterio sclerosis & Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Feb. 1969 1962	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from Aug 12, 1962 to Apr 17, 1969 , that (I) (we) last saw the deceased alive on Aug 12, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE James E. Nolan MD					DEGREE MD		22c. DATE SIGNED 4-17-69		
22d. PHYSICIAN'S NAME (Type) JAMES E. NOLAN					22e. ADDRESS 5401 Western Ave NW				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery Co., Md.			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.					25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

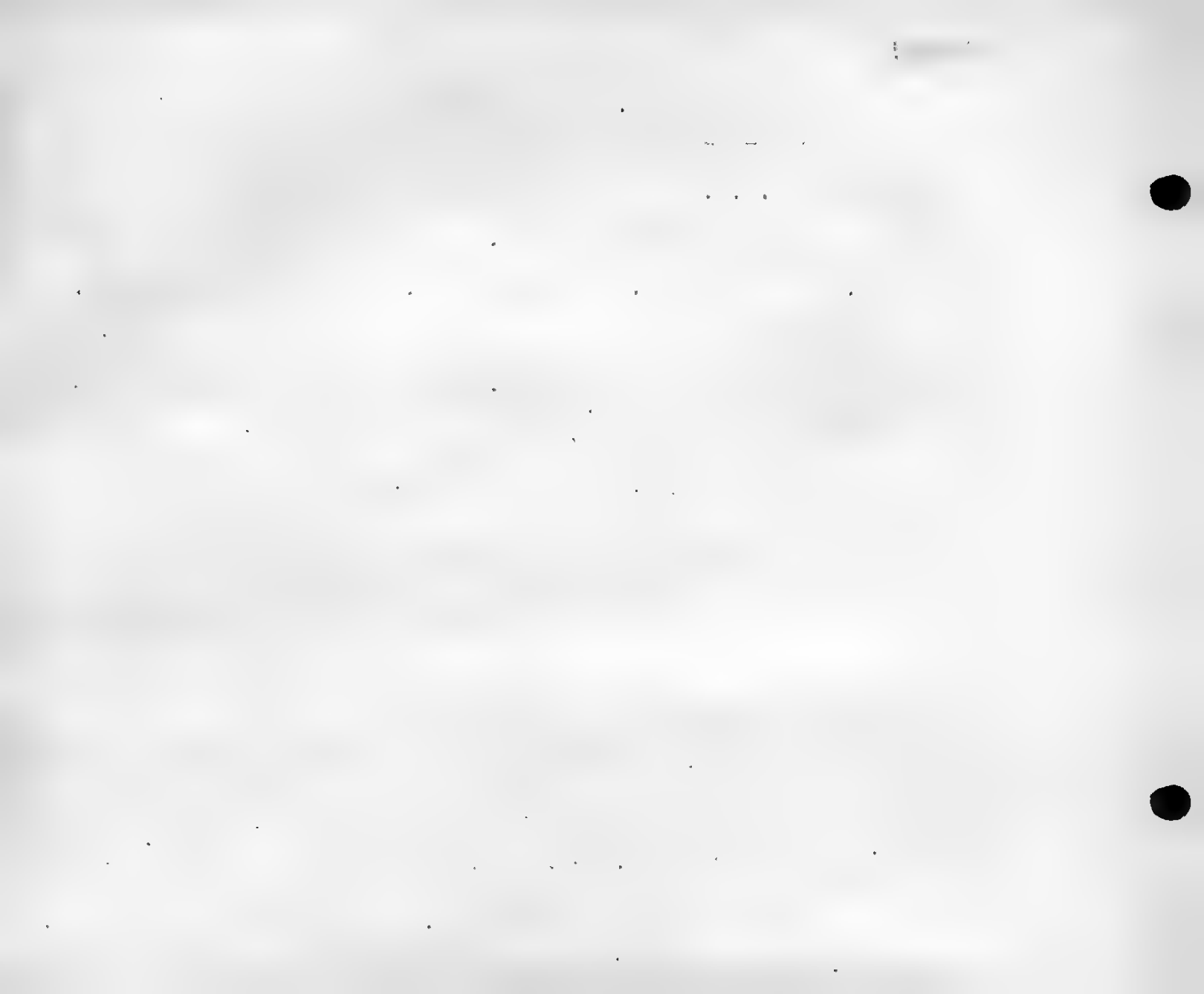
05601

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05596

1. DECEASED NAME (Type or Print) Annie M. Dimmie			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month 4 Day 25 Year 1969			2b. HOUR 9 PM	
3 SEX Fe	4 RACE Negro	5 DATE OF BIRTH 1-26-1890	6 AGE (n years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 4 Day 25 Year 1969	2d. HOUR 9 PM
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Norbeck		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 15720 Bradford Rd.		12a. USUAL OCCUPATION (Kind of work done during most of last year, if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm'ssion) STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Norbeck		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Unknown Middle Unknown Last Unknown		15. MOTHER'S MAIDEN NAME First Kissie Middle Anderson Last Anderson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			
16b. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Helen Hatton (daughter)		ADDRESS same as above		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. with metastasis. (b) with metastasis. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADJUTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED May 2, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-3-69		23c. NAME OF CEMETERY OR CREMATORY SHILOH BAPTIST CEM		23d. LOCATION (City or Town) (County) (State) PALMYRA FLUVANNA VA.	
24. FUNERAL DIRECTOR ROBERT L. SNOWDEN				ADDRESS ROCKVILLE, MD		25a. RECD BY REGISTRAR MAY 5 1969 25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR 1534
45M 1969

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
05602														
0559														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First JOHN		Middle Raymond		Last DONALDSON, JR		2a. DATE OF DEATH Month Day Year APRIL 2 1969		2b. HOUR 8:10 PM			
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH 3/18/00			6. AGE (In years last birthday) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY			Md.		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY Trans			-it. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE West VA			13b. COUNTY Jefferson			13c. CITY OR TOWN SHEPARDSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER MAIN ST		
14. FATHER'S NAME First Middle Last JAMES DONALDSON			15. MOTHER'S MAIDEN NAME First Middle Last EMMA COLLINS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No ***			16b. SOCIAL SECURITY NO. 579-26-1878			17. INFORMANT Address same as above Wife Mary Donaldson		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (a) _____ (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR AM Month Day Year PM 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Sept, 1959, to 2 Apr, 1969, that (I) (we) last saw the deceased alive on 1 Apr 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE John M. Wyman			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 2 Apr 69							
22d. PHYSICIAN'S NAME (Type) John M. Wyman			22e. ADDRESS 7801 Montclair Ave. Bethesda Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-5-69		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery			23d. LOCATION (City or Town) (County) (State) Bethesda, Montg. Co. Md.						
24. FUNERAL DIRECTOR Robert A. Humphrey			ADDRESS 7552 Wilkes Ave				25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05603

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05598

1. DECEASED-NAME (Type or Print) <u>Jo - Ann</u>			First Middle Last			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <u>April 3, 1969</u>			2b. HOUR <u>10:30</u> M		
3. SEX <u>female</u>	4. RACE <u>colored</u>	5. DATE OF BIRTH <u>2/23/43</u>	6. AGE (in years last birthday) <u>26</u> YRS	IF UNDER 1 YEAR MONTHS <u>8</u> DAYS		IF UNDER 24 HRS HOURS <u>8</u> MIN		2c. DATE PRONOUNCED DEAD Month <u>April</u> Day <u>30</u> Year <u>1969</u>			2d. HOUR <u>10:30</u> M
7a. BIRTHPLACE (State or foreign country) <u>Darlington</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u>			Md		
10. CITY OR TOWN OF DEATH <u>Bethesda</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Home Medical Institute</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Germantown</u>	13d. INS DE CITY LIM-157 YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Chopper Rd - Rt. 2</u>			
14. FATHER'S NAME First Middle Last <u>William Battle</u>			15. MOTHER'S MAIDEN NAME First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16b. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT <u>Faul Weaver Hershey</u>			ADDRESS <u>1501 Pine</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mitral Stenosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatic Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>years</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John B. Bell</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>May 4, 1969</u>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>5-6-69</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md</u>		
24. FUNERAL DIRECTOR <u>Robert S. Gaudin</u>				ADDRESS <u>Rockville, Md</u>				25a. REC'D BY REGISTRAR <u>MAY 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

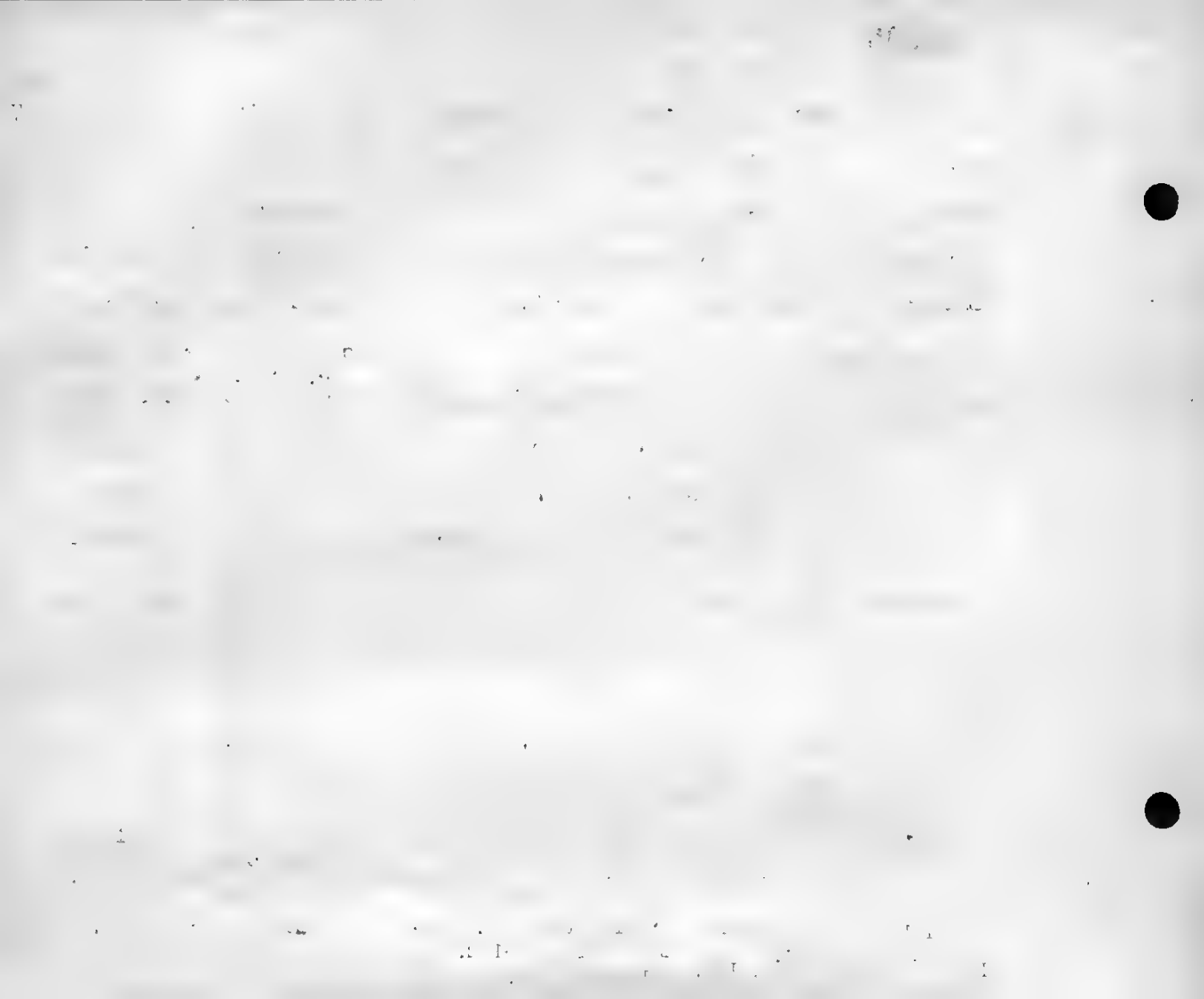
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05604 CERTIFICATE OF DEATH 05593										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Donald William Doss						April 23, 1969		2:45 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 24 HRS		
Male		White		May 12, 1890		78 YRS.		MONTHS DAYS HOURS M.M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Iowa		America				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Sanitarium			Painter--Carpenter				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Rockville		YES		5807 Worcester Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Dan Doss			Alice Rea							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			217-0903523-4		Patient's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Acute Bronchitis</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from January, 1969, to 4-23, 1969, that (I) (we) last saw the deceased alive on 4-22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Stuart L. Nelson									4-23-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
STUART L. NELSON					ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4/25/69		MEADOW BRANCH CEMETERY		WESTMINSTER, P.D. MD.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. E. Myers, Jr., Westminster, Md.							APR 25 1969		J. E. Myers, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05605										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05600									
Item #7a, Film G: 12 5/14/69 km										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Jesse Carl Downing										April 27, 1969										11:57 PM									
3 SEX										4. RACE										5. DATE OF BIRTH									
Male										White										17 April 1919									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
Washington DC										USA										Montgomery Md.									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)									
Bethesda										The Clinical Center, NIH										Press Secretary									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN									
Virginia										Arlington										Arlington									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)									
Jesse Downing										Mamie Bruce										No									
16b. SOCIAL SECURITY NO.										17. INFORMANT										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
Not Available										Bethesda, Md. 20014										PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest									
																				Minutes									
																				Days									
																				Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that xxx (this hospital) attended the deceased from 10 April, 1969, to 27 April, 1969, that xx (we) last saw the deceased alive on 27 April, 1969, and that in xxx (our) opinion death occurred on the date and hour and from the causes stated above, xx (we) (did) (do not) view the body after death.																													
22b. SIGNATURE										22c. DATE SIGNED										22d. ADDRESS									
Howard H. Kaufman MD										28 April 1969										The Clinical Center, National Institutes of Health, Bethesda, Md.									
22d. PHYSICIAN'S NAME (Type)										23a. NAME OF CEMETERY OR CREMATORY										23b. DATE									
Howard H. Kaufman, MD.										National Memo. Park										4-30-1969									
23c. BURIAL, CREMATION, REMOVAL (Specify)										23d. LOCATION (City or Town) (County) (State)										23e. RECORD BY REGISTRAR									
Burial										Falls Church Va.										MAY 1 1969									
24. FUNERAL DIRECTOR										25a. RECORD BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Ives Funeral Home, Inc.										2847 Wilson Blvd. Arlington, Va.										Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR AIS 1
45M - 1269

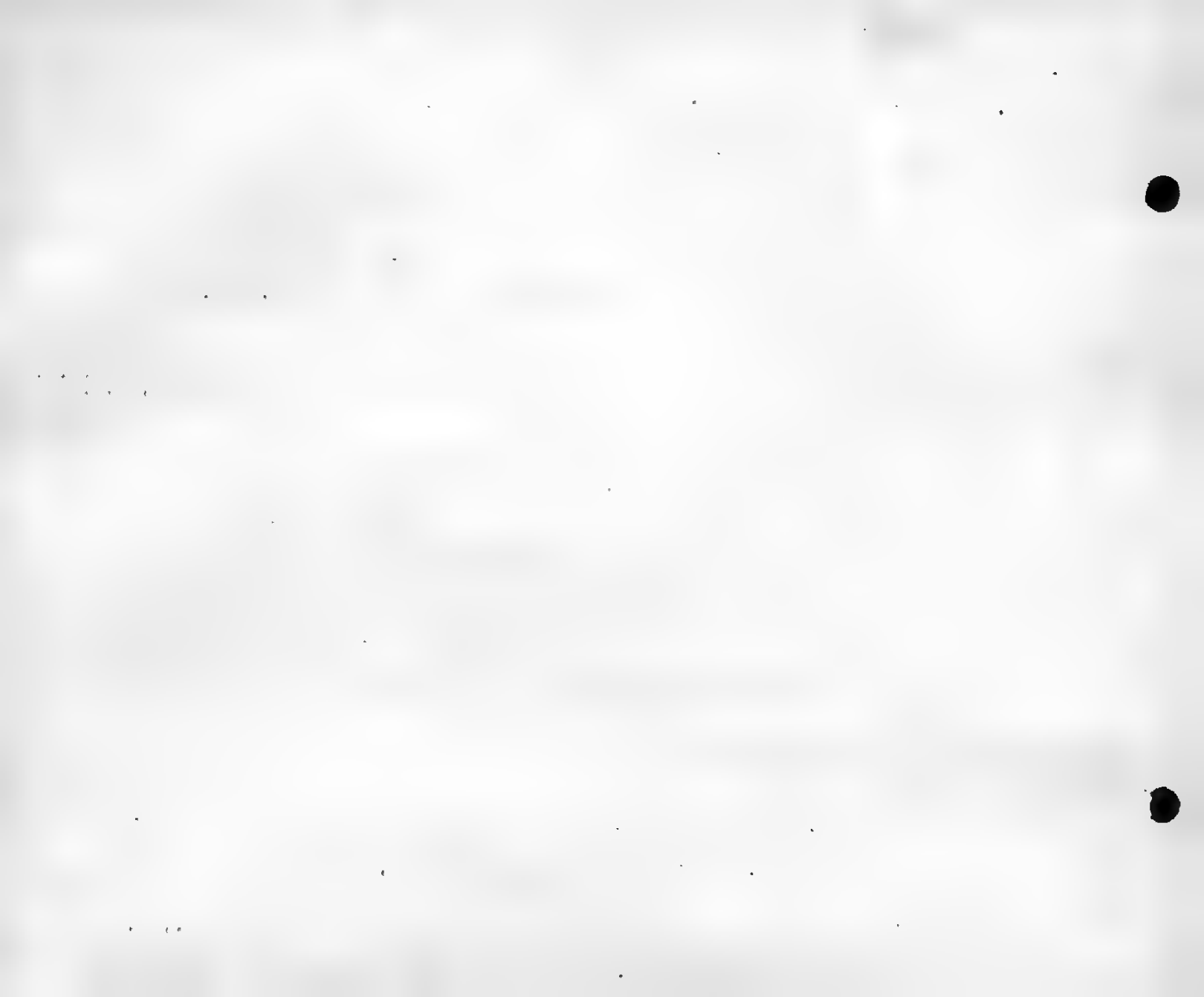
05606

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05601

1. DECEASED NAME (Type or print) KITTIEBEL			First C.			Middle DURLAND			Last			2a. DATE OF DEATH Month 4 Day 7 Year 1969			2b. HOUR 5 30 AM								
3. SEX FEMALE			4 RACE WHITE			5 DATE OF BIRTH 9/12/177			6 AGE (n years last birthday) 91 YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN								
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY County Md														
10. CITY OR TOWN OF DEATH ROCKVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) TYSON WHEELER FUNERAL HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE New York			13b. COUNTY Elmira			13c. CITY OR TOWN Elmira			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 616 W. 1st. Street											
14. FATHER'S NAME William Porter Chapman			First William			Middle Porter			Last Chapman			15. MOTHER'S M.A.DEN NAME Elizabeth Jones			First Elizabeth			Middle Jones			Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. 071-09-96981			17 INFORMANT Mrs Larned Blatchford			3900 Watson Place, N.W. Washington, D.C.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. 4339 IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs Indefinite								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from 8/6/1967 to 4/7/1969 , that (I) (we) last saw the deceased alive on 4/2/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Stephen N. Jones			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 4/7/69														
22d. PHYSICIAN'S NAME (Type) Stephen N. Jones			22e. ADDRESS Rockville, Maryland																				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE 4/7/69			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.														
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.																							
25a. REC'D BY REGISTRAR APR 11 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on in any event, within 72 hours after death.

Deceased - Medical Examinee

05607		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05602	
1 DECEASED-NAME (Type or print) First Middle Last Harry Leonard Easton		2a DATE OF DEATH Month Day Year April 12 69		2b. HOUR 6 a.m	
3. SEX Male		4 RACE White		5. DATE OF BIRTH Aug. 17th 1903	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Sandy Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Construction	
13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Sandy Spring	
14 FATHER'S NAME First Middle Last Harry Shield Easton		15. MOTHER'S MAIDEN NAME First Middle Last Carrie S Disney		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no known		16b SOCIAL SECURITY NO 216-10-6509		17 INFORMANT Address Mrs. Harry L. Easton Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Coronary Heart Disease Conditions, if any, which gave rise to mimmed ota cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. yes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/10/69 to 4/12/69 , that (I) (we) last saw the deceased alive on 4/10/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		22c. DATE SIGNED 4/12/69		22d. PHYSICIAN'S NAME (Type) Dr. C.H. Ligon	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Friends	
24. FUNERAL DIRECTOR Francis H. Barber		25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
23d. LOCATION (City or Town) (County) (State) Sandy Spring Mont. Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

05608		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		05603	
1 DECEASED NAME (Type or print) <i>Mary B. Emmert</i>			2a DATE OF DEATH <i>4</i> Month <i>4</i> Day <i>69</i> Year <i>9A</i>			2b HOUR	
3 SEX <i>Female</i> RACE <i>White</i>			5. DATE OF BIRTH <i>9-30-84</i>			6. AGE (In years last birthday) <i>87</i> YRS.	
7a. BIRTH-PLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>NONE</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Gaithersburg</i>		13d MS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>15 Bechtelum Avenue</i>		14 FATHER'S NAME First <i>ISAC</i> Middle <i>N</i> Last <i>EMMERT</i>		15. MOTHER'S MA DEN NAME First <i>MARY</i> Middle <i>A.</i> Last <i>SHAFER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>220-442018</i>		17. INFORMANT <i>LAURA H. CLAGETT - DAUGHTER</i>		Address <i>111 S. Summit Ave Gaithersburg, Md.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1966</i> , 19 <i>1969</i> , to <i>April 4, 1969</i> , that (I) (we) lost saw the deceased alive on <i>4/3</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>L. L. Leal</i> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <i>L. L. Leal</i>				22e. ADDRESS <i>Gaithersburg Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>4/7/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Rose Hill</i>		23d LOCATION (City or Town) (County) (State) <i>Hagerstown Town. Md.</i>	
24. FUNERAL DIRECTOR <i>W.C. Nith</i>		ADDRESS <i>Barneville Md.</i>		25a. REG. BY REGISTRAR <i>APR 9 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	

MEDICAL CERTIFICATION

1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Med. Examiner

05609										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05604									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR A									
First Middle Last William George Evans III										Month 4 Day 9 Year 69										12:56									
3 SEX Male					4 RACE White					5. DATE OF BIRTH 6/12/34					6. AGE (in years last birthday) 34 YRS.					F UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) W. Va.					7b. CITIZEN OF WHAT COUNTRY? U.S.					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md														
10. CITY OR TOWN OF DEATH Silver Spring Md.					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address) Holy Cross Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Systems Analyst					12b. KIND OF BUSINESS OR INDUSTRY DataProcess														
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.					13b. COUNTY Pr. Geo.					13c. CITY OR TOWN Bowie					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 12845 Holiday Lane									
14. FATHER'S NAME First Middle Last William George Evans Jr.										15. MOTHER'S MAIDEN NAME First Middle Last Marguerite Garlach																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes										16b. SOCIAL SECURITY NO. 1957-59					17. INFORMANT Sylvia Evans					Address 12845 Holiday La Bowie Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> 569.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 1967 to 4/9 1969, that (I) (we) last saw the deceased alive on 4/9 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE G. Lennard Gold										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 4/9/69														
22d. PHYSICIAN'S NAME (Type) G. Lennard Gold										22e. ADDRESS 9801 Ga. Ave. Silver Spring, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE April 14, 1969					23c. NAME OF CEMETERY OR CREMATORY Woodmere Cemetery					23d. LOCATION (City or Town) (County) (State) Huntington, West Virginia														
24. FUNERAL DIRECTOR C. Glen Carter Warner E. Pumphrey, Inc.										25a. REC'D BY REGISTRAR APR 17 1969										25b. REGISTRAR'S SIGNATURE V. Clements Under									

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

05610

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05605

1. DECEASED NAME (Type or Print) <u>Georgia J. Fahey</u>			First <u>Georgia</u> Middle <u>S.</u> Last <u>Fahey</u>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <u>April</u> DAY <u>30</u> YEAR <u>1969</u>			2b. HOUR <u>09</u>		
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>May 5, 1896</u>		6. AGE (In years last birthday) <u>72</u> YRS		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN. <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Montgomery</u>		
10. CITY OR TOWN OF DEATH <u>Bethesda</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Private</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>Md.</u>			13b. COUNTY <u>Montgomery</u>			13c. CITY OR TOWN <u>Bethesda</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First <u>Samuel</u> Middle <u>Kirtley</u> Last <u>Fahey</u>			15. MOTHER'S MAIDEN NAME First <u>Mina</u> Middle <u>-</u> Last <u>-</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16b. SOCIAL SECURITY NO. <u>-</u>		
17. INFORMANT <u>William Fahey</u>			ADDRESS (502) <u>Samuel Fahey</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			DUE TO, OR AS A CONSEQUENCE OF			years.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <u>Coronary Arterio Sclerosis</u>			DUE TO, OR AS A CONSEQUENCE OF			years.		
			(c) <u>Hypertensive Cardio Vascular Disease</u>						years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John J. Ball</u>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>May 4, 1969</u>		
EXAMINER'S NAME (Type) <u>John J. Ball</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>5-5-1969</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Suitland, Prince Georges Co., Md.</u>		
24. FUNERAL DIRECTOR <u>JOSEPH GAYLER'S SON, INC.</u>			ADDRESS <u>5130 WISC. AVE., N. W. WASH., D. C. 20016</u>			25a. REC'D BY REGISTRAR <u>MAY 6 1969</u>			25b. REGISTRAR'S SIGNATURE <u>James J. Ball</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

05611

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05606

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 9:05 PM				
3. SEX F		4. RACE White		5. DATE OF BIRTH 9/23/03		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shurman		12a. USUAL OCCUPATION (Kind of work done during most of work as life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE DC		13b. COUNTY ***		13c. CITY OR TOWN Wash.		13d. INSIDE CITY, IN TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6200 Midway Road			
14. FATHER'S NAME James Earl Stenger		First	Middle	Last	15. MOTHER'S MAIDEN NAME Elizabeth Bates		First	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 519 24 2850		17. INFORMANT Mary George		Address Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4319 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) Diverticulitis & Carcinoma Sigmoid Colon											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 3-24, 1969, to 4-14, 1969, that (I) (we) last saw the deceased alive on 4-14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ira Miller M.D.		DEGREE		ATTENDING PHYS		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-15-69			
22d. PHYSICIAN'S NAME (Type)		IRA MILLER, M.D.		22e. ADDRESS 8218 Wisconsin Ave, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-17-69		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Stephens City, Virginia					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		755 ADDRESS 755 Wisconsin Ave		REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

Cleared & medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

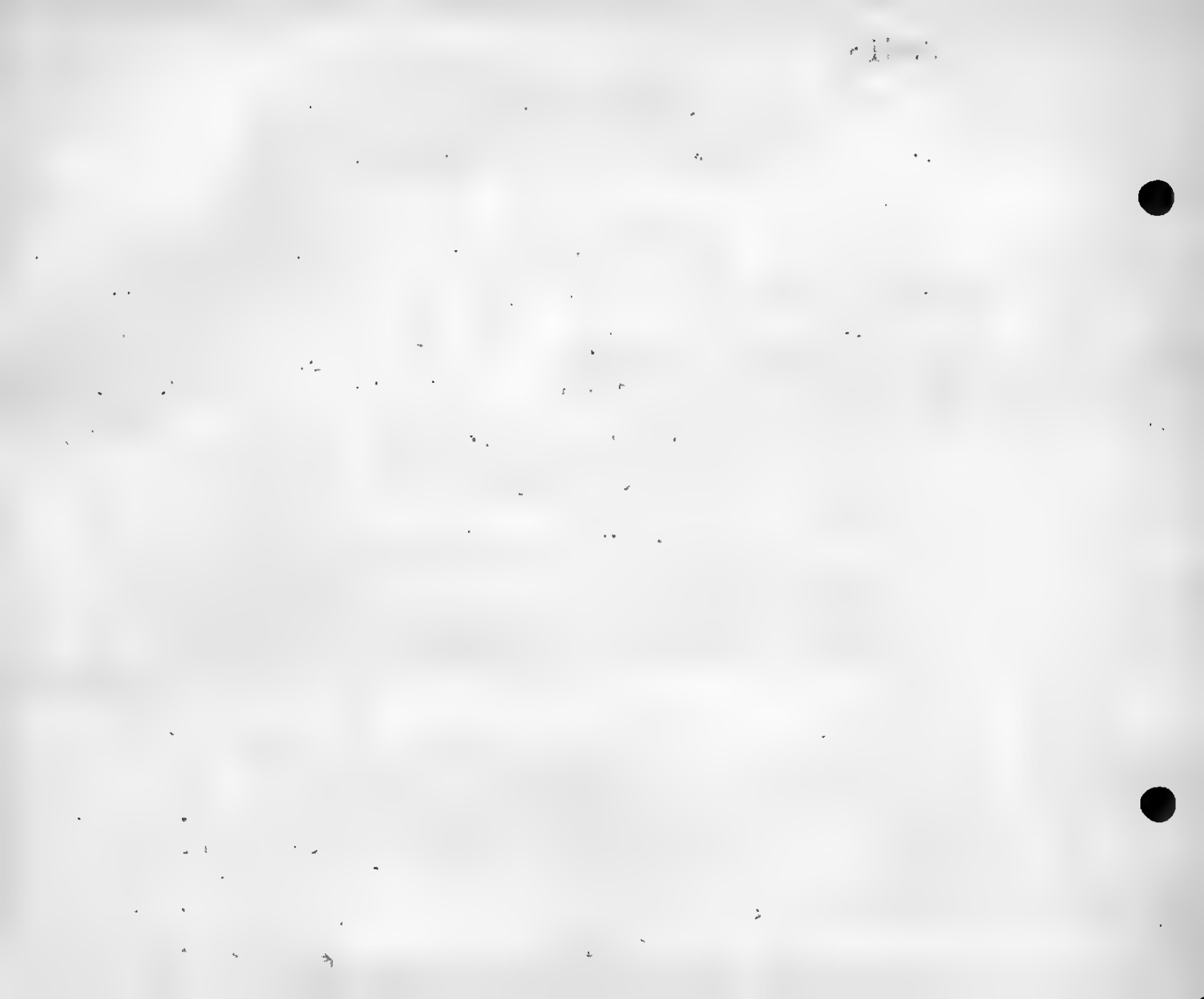
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05612		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05612		
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
FRASER, JAMES S. FRASER					Month 4 Day 20 Year 69		3 30 M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	white		May 2, 1886		82 YRS.		IF UNDER 24 MRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Washington, D.C.	U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Kensington, Md.		9611 Hillridge, Drive.		Accountant. Ret.		Realestate		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Florida		Broward		Deerfield.		512-N.E. 21st. Ave.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown)		16b. SOCIAL SECURITY NO.		
Charles Edward Fraser		Georgianna N.M.N. Anderson		No		220-44-2371-J#1		
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum & metastases</u> DUE TO, OR AS A CONSEQUENCE OF <u>1 year</u> (b) <u>1 year</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Doris F. Canova		9611 Hillridge, Dr. Kensington, Md						
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-1, 1969</u> to <u>4-20, 1969</u> , that (I) (we) lost saw the deceased alive on <u>4-15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Jason Berger, M.D.</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-20-69</u>		22d. PHYSICIAN'S NAME (Type) <u>JASON BERGER, M.D.</u>		
22e. ADDRESS <u>800 PERSHING DRIVE SILVER SPRING, MD.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>4/21/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		
23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>		24. FUNERAL DIRECTOR <u>Lee Funeral Home</u> ADDRESS <u>300-4th. St. N.E.</u>		25a. APR BY REGISTRAR <u>APR 29 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
05613						05608									
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print) Milton				First Milton		Middle (NMN)		Last Fried		2a. DATE OF DEATH Month April Day 4 Year 1969			2b. HOUR 7:30 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 20 November 1915			6. AGE (In years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Economist			12b. KIND OF BUSINESS OR INDUSTRY Trade Union						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York			13b. COUNTY 			13c. CITY OR TOWN New York		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 351 W. 24th Street					
14. FATHER'S NAME Louis				First Louis		Middle I.		Last Fried		15. MOTHER'S MAIDEN NAME Helen				First Helen Middle Last Gelfand	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give year or dates of service)				16b. SOCIAL SECURITY NO. Not Available		17. INFORMANT Bethesda, Md. 20014 Address The Medical Records, The Clinical Center,									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebellar subarachnoid hemorrhage												Terminal			
398 X DUE TO, OR AS A CONSEQUENCE OF (b) Acute renal failure												3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic heart disease												years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Systemic Lupus Erythematosus															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that Dr. (this hospital) attended the deceased from 19 March , 1969, to 4 April , 1969, that (H) (we) last saw the deceased alive on 4 April , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (H) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Joseph L. Goldstein, M.D.						22c. DATE SIGNED 5 April 1969			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE Apr. 5, 1969			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) New York, N.Y.						
24. FUNERAL DIRECTOR B. H. Langworthy, Jr. ADDRESS 3621-14 St. N.E. Wash. D.C.						25a. REC'D BY REGISTRAR APR 10 1969			25b. REGISTRAR'S SIGNATURE W. H. Chamberlain, Jr.						



05614

05609

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last MAURICE MNM FRIEDMAN			2a. DATE OF DEATH 4-19-69 Month Day Year		2b. HOUR 1:55 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 11-23-14		6. AGE (in years) 54 (1st birthday)	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) D.C. Balto. Md		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY CO.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. ST. AND HOSP.		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) DRIVER BLUE LINE SIGHSELLING CO.	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY Mont	13c. CITY OR TOWN SS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 11385 COLUMBIA PIKE
14. FATHER'S NAME First Middle Last ISAAC FRIEDMAN			15. MOTHER'S MAIDEN NAME First Middle Last IDA NORE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT HOSP RECORD Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HOURS YRS.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>spring</u> , 1964, to <u>4-19</u> , 1969, that (I) (we) last saw the deceased alive on <u>around 4-1</u> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Albert H. Grollman M.D.</u>		22c. DATE SIGNED 4-19-69		22d. PHYSICIAN'S NAME (Type) ALBERT H. GROLLMAN	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/21/69		23c. NAME OF CEMETERY OR CREMATORY OHEV-SHOLOM TALMUD TORAH CEM. - WASH. D.C.	
23d. LOCATION (City or Town) (County) (State) BALTIMORE MONTGOMERY MD		24. FUNERAL DIRECTOR ADDRESS Bernard Danzansky & Sons. 301-1425 14 W. WASH. D.C.		25a. REC'D BY REGISTRAR APR 22 1969	
				25b. REGISTRAR'S SIGNATURE H. L. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by medical examiner - Dr. Kelly

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05615		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05610	
Item 588 Film 411 7/25/69 kk					
1. DECEASED-NAME (Type or print) Lawrence E Fuller			2a. DATE OF DEATH April 29 1969		2b. HOUR 4:30 PM
3 SEX MALE	4. RACE White	5. DATE OF BIRTH 1-9-1895		6. AGE (In years last birthday) 74	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired.) PRODUCER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN GAITHERSBURG	13d. HAS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 20 CHESTNUT ST.
14. FATHER'S NAME First HENDERSON Middle FULLER Last		15. MOTHER'S MAIDEN NAME First Unknown Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT STARLE FULLER 112 DEER PARK DR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C H F					1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute myo card infarction					1 week
DUE TO, OR AS A CONSEQUENCE OF (c) ASHD					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema BPH, Umy but infarction, Right V. disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (the hospital) attended the deceased from 4-25 , 19 69 , to 4-29 , 19 69 , that (I) (we) last saw the deceased alive on 4-28 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John S. Soia		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-29-69	
22d. PHYSICIAN'S NAME (Type) John S Soia		22e. ADDRESS 809 Viers Mill Road Rockville, Md			
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE 4-3-69		23c. NAME OF CEMETERY OR CREMATORY Roselawn Mem Gardens	
23d. LOCATION (City or Town) Mercer County W. Va		(County) (State)			
24. FUNERAL DIRECTOR Robert A Pumphrey		ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR MAY 5 1969	
25b. REGISTRAR'S SIGNATURE Charles George					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

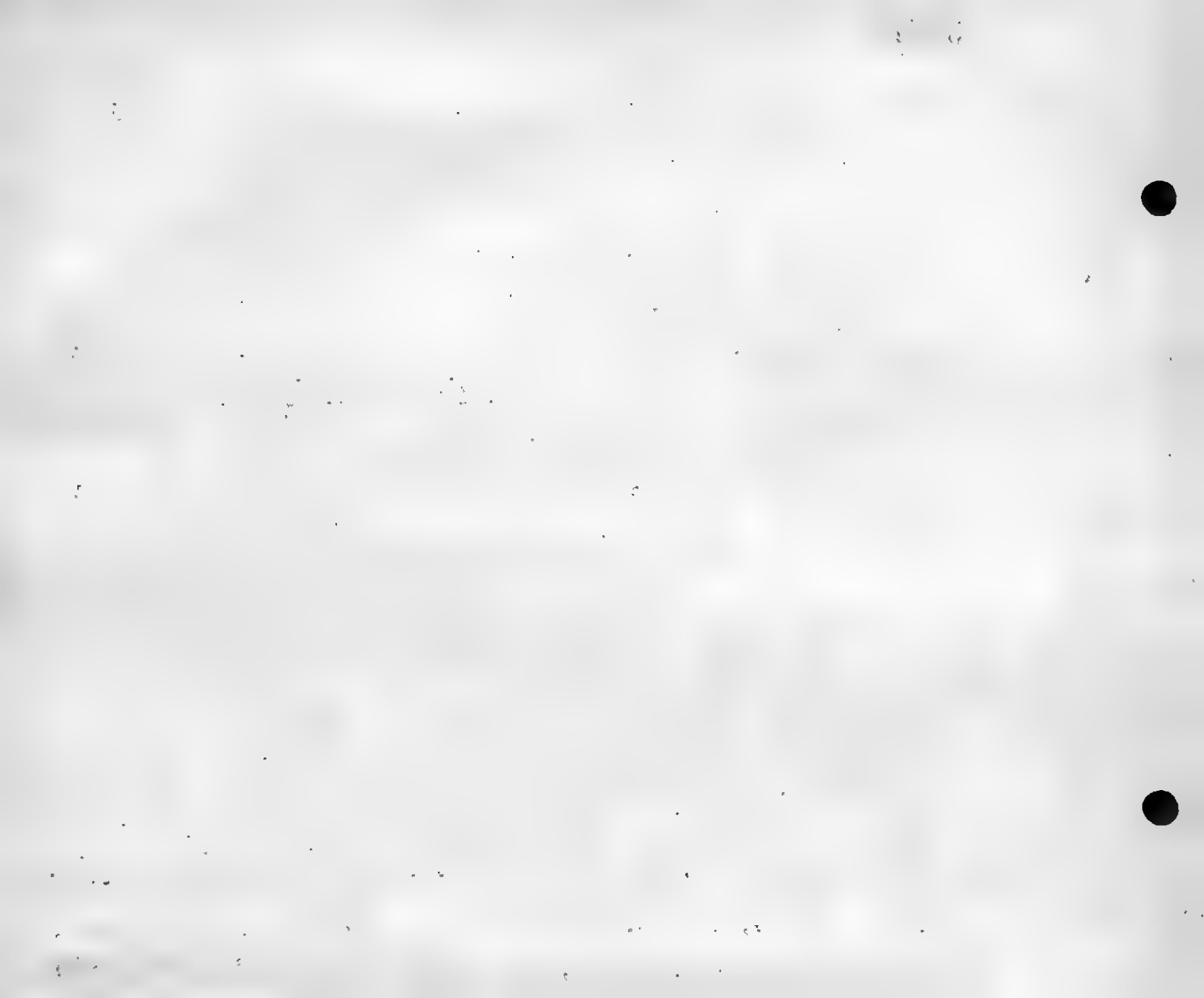
05616

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05616

1. DECEASED-NAME (Type or print) Karl Kennedy Gaskins			2a. DATE OF DEATH Month April Day 1 Year 1969			2b. HOUR 11:15 MIN AM	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 28 July 1961		6. AGE (In years last birthday) 7 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Fauquier		13c. CITY OR TOWN Delaplane		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER RFD, Box 52		14. FATHER'S NAME First William Middle P. Last Gaskins		15. MOTHER'S MAIDEN NAME First May Middle Dorothy Last Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. none		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda Md 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 2040 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Systemic Cryptococcosis DUE TO, OR AS A CONSEQUENCE OF (c) Acute Lymphocytic Leukemia							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Hours 1 Month 8 Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 22 August, 1968 , to 1 April, 1969 , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on 1 April, 1969 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert E. Gallagher, M.D.				22c. DATE SIGNED 1 April 1969		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda Md., 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Apr. 5, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Morris		23d. LOCATION (City or Town) (County) (State) Hume Fauquier Va.	
24. FUNERAL DIRECTOR Royston Funeral Home Marshall, Va.				25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05617

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05612

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			Month	Day	Year	2b HOUR
Gilbert Davis George						MAY 4 8 1969						2 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d HOUR	
M.	W.	March 20 1925		44 YRS	MONTHS		DAYS		Month Day Year		12 PM	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		Md		
		U.S.A.		WIDOWED		DIVORCED		Montgomery				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Potomac			8521 Victor Lane			Salesman			Real Estate			
13a USUAL RESIDENCE (Where deceased lived, admission)			13b. COUNTY			13c. INSIDE CITY LIMITS?			13e STREET AND NUMBER			
Md.			Montgomery			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5805 Roosevelt St.			
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Albert T. George			Dolly Davis									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT						
Yes			W.W. II			5805 Roosevelt Street, Mrs. Helen C. George, Bethesda, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning -												
DUE TO, OR AS A CONSEQUENCE OF (b) Inhaling Auto Exhaust -												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
				? 4/8 1969				Connected to exhaust pipe car to rear window -				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State				
				Garage of Home				8521 Victory La. Potomac - Montgomery Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				M.D.				ASSISTANT MEDICAL EXAMINER				
JOHN G. BALL, M.D.								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county)				Montgomery Co. Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)						
Cremation		4-9-69		Cedar Hill Crematory		Suitland, Pr. Geo. Md.						
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Md.				DATE APR 15 1969				Phonix Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

05618

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05613

1. DECEASED-NAME (Type or print) Nicholas XXXXXXXX		Middle O.	Last Gerard	2a. DATE OF DEATH Month 4 Day 30 Year 69		2b. HOUR 7:39 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 21, 1922		6. AGE (in years last birthday) 47 RS.	
7a. BIRTHPLACE (State or foreign country) California		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Administrator		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Dr.,		13f. STREET AND NUMBER 13607 Colefax					
14. FATHER'S NAME First Nicholas V Middle Gerard Last West		15. MOTHER'S MAIDEN NAME First Marguerite Middle West Last West					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SECURITY NO WW II 186-16-7742		17. INFORMANT Mrs. Ann Gerard, Widow, same as item #13		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Massive myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) Massive myocardial infarct Approximate interval between onset and death minutes minutes							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 1958 to April 30, 1969 , that (I) (we) last saw the deceased alive on April 27, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard Delaney		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Richard Delaney		22e. ADDRESS 4323 Harvard, Silver Spring, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE 5-1-1969		23c. NAME OF CEMETERY OR CREMATORY West Wyoming Cemetery		23d. LOCATION (City or Town) (County) (State) West Wyoming, Pennsylvania	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave., N.W., Washington, D.C., 20016				25a. REGISTRY MAY 6 1969		25b. REGISTRAR'S SIGNATURE John A. [Signature]	

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>Items 5, 6, 13 & 17</div> <div>Film Roll 4/21/69</div> <div>05619</div> <div>CERTIFICATE OF DEATH</div> <div>05614</div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
SARAH			K. Ginsburg			Month Day Year			12 PM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female	White		6-3-00			70 YRS.		MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
Russia			U.S.A.			Montgomery			Md.
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring			Holy Cross			HOUSEWIFE			-
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. STREET AND NUMBER			13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>
Md			Montgomery			11715 OAKLEAF DR			SSPG.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO
YITZHAIR			DIANE			No			578-50-815
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
MANNY GINSBURG			Pneumonia - Klebsiella - Pseudomonas			10107 Devere Court, S.S. Md.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21a. INJURY OCCURRED			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
22a. I certify that (I) (this hospital) attended the deceased from			22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)
4-3-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			G. B. Cushner, M.D.			4-4-69			G. B. Cushner, M.D.
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			4-6-69			G.W. Cem., Inc			HYATTSVILLE MD.
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE
Charles Judge			APR 8 1969			Charles Judge			APR 8 1969

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05620

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

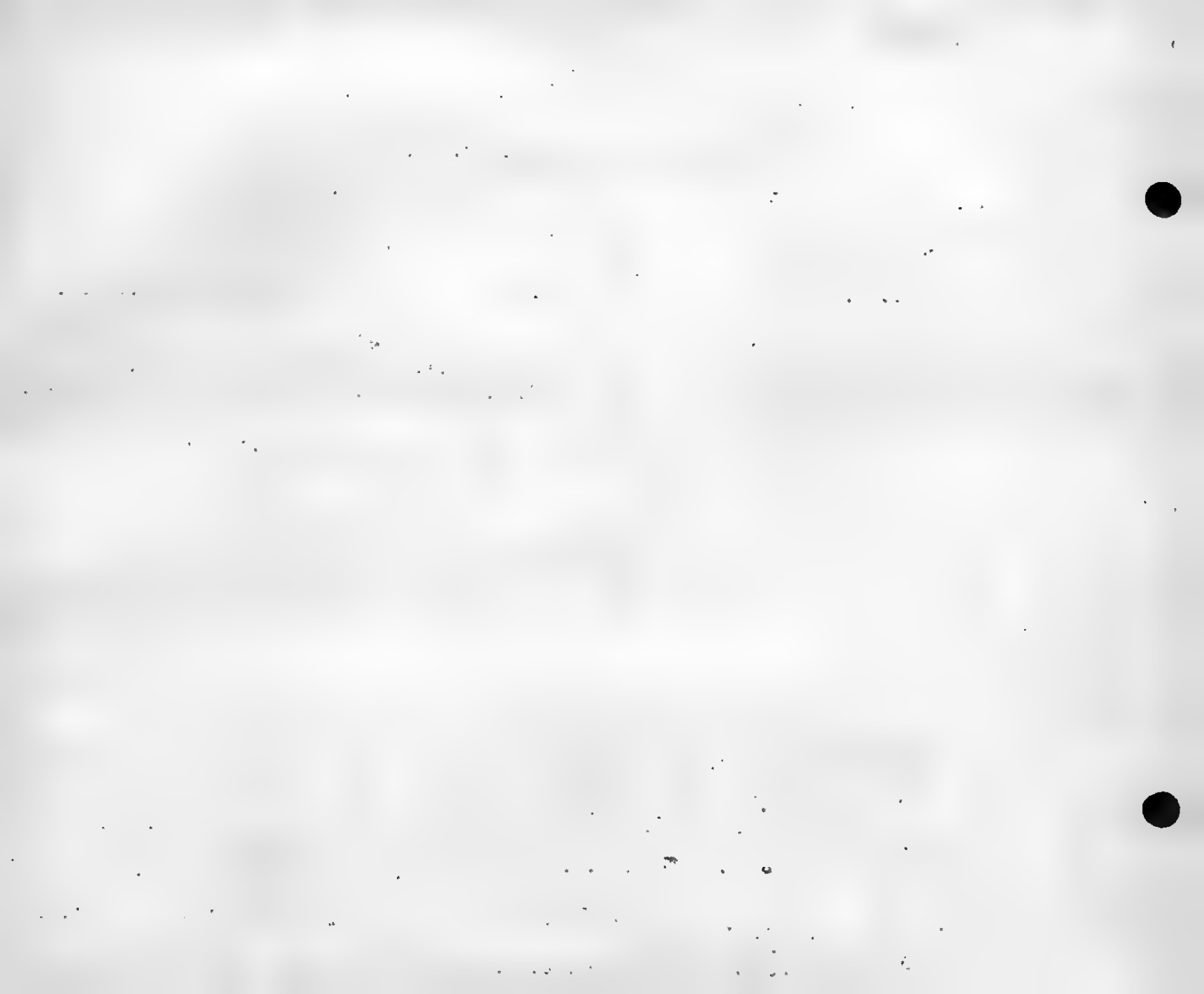
05615

1. DECEASED-NAME (Type or print) <u>Dominic E. Gioffre Jr.</u>			2a. DATE OF DEATH Month <u>April</u> Day <u>11</u> Year <u>1969</u>			2b. HOUR <u>11:00 P.M.</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>April 24, 1949</u>		6. AGE (in years lost birthday) <u>19</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery County</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital of Silver Spring</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>LABORER</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Upper Marlboro</u>		13c. CITY OR TOWN <u>UPPER MARLBORO</u>		13e. STREET AND NUMBER <u>9901 Central Avenue</u>	
14. FATHER'S NAME First <u>Dominic</u> Middle <u>E</u> Last <u>Gioffre</u>		15. MOTHER'S MAIDEN NAME First <u>Dorothy</u> Middle <u>Sweeney</u> Last <u>Sweeney</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT <u>Dominic E Gioffre, Sr</u> Address <u>9901 Central Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>liver failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>mitral valve ported carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <u>4/9</u> , 19 <u>69</u> , to <u>4/11</u> , 19 <u>69</u> , that (1) (we) last saw the deceased alive on <u>4/11</u> , 19 <u>69</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Lewis William Dennis MD</u>		22c. DATE SIGNED <u>4/11/69</u>		22d. PHYSICIAN'S NAME (Type) <u>Lewis William Dennis MD</u>		22e. ADDRESS <u>3406 Bel Pre Rd. Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-14-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Clinton PG Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert E Wilhelm Funeral Home</u> <u>4308 Suitland Road Suitland Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>APR 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Y. Charles Young</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05621										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05616			
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR								
Victor					H GOODMAN					April Month 21 Day Year 69					409P M								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.								
Male			Negro			Sept. 28, 1927			41 YRS.			MONTHS DAYS			HOURS MIN								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH														
N. Carolina			USA						Montgomery Md.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda					Naval Hospital					Unknown													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER							
D. C.					Washington					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			928 Ingraham St., N.W.										
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																		
First Middle Last					First Middle Last																		
James G. Goodman					Letha Holtzclaw																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address								
Yes <input checked="" type="checkbox"/> (If yes give war or dates of service)										S.E., Washington, D.C.													
Yes WWII, Korea										Mrs. Berlyne A. Handy, 34th & Alabama Aves.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 1. DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) <u>Acute renal failure by history with acute pulmonary edema; status postoperative gastrectomy</u>																							
DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
(b) _____																							
DUE TO, OR AS A CONSEQUENCE OF																							
(c) _____																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
					HOUR A.M. Month Day Year P.M. 19																		
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION					21g. CITY OR TOWN								
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										Street or R.F.D. No.					County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Mar. 19</u> , 19 <u>69</u> , to <u>Apr. 21</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <u>Apr. 21</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE					22c. DATE SIGNED																		
<i>Donald K. Roeder, M.D.</i>					Apr. 23, 1969																		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS																		
Donald K. ROEDER, M.D.					Naval Hospital, Bethesda, Md.																		
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)								
Burial					4/25/69					Salisbury National Cemetery					Salisbury, N.C.								
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE													
Butler Funeral Home					APR 25 1969					<i>Charles Judge</i>													
3900 Georgia Ave., N.W. Washington, D. C.																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1-69

05622		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05617	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print) <i>Percy Parker Brady</i>			First Middle Last		2a DATE OF DEATH Month Day Year <i>April 28 1969</i>		2b HOUR <i>1:08 PM</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>4/21/1912</i>		6. AGE (In years last birthday) <i>57</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Wash DC</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <i>7820 Tilbury St.</i>		14. FATHER'S NAME First Middle Last <i>Percy J. Brady</i>		15 MOTHER'S MAIDEN NAME First Middle Last <i>Cornelia PARKER</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b SOCIAL SECURITY NO.		17. INFORMANT <i>Don Dennis M. Brady</i>		Address <i>19111 Redwood Dr</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <i>Cirrhosis of Liver</i> 5719 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4-28-69</i> , 19 <i>68</i> , to <i>4-28</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-28-69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE <i>Paul D Cantor</i>		22c. PHYSICIAN'S NAME (Type) <i>Paul D Cantor Md</i>		22d. ADDRESS <i>4709 Montgomery Ave Bethesda, Md</i>		22e. DATE SIGNED <i>4/28/69</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-1-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>	
24 FUNERAL DIRECTOR <i>Robert A Pumphrey</i>				25a. REC'D BY REGISTRAR <i>MAY 5 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles W. Viggie</i>	

St Paul Notified

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
05623									
05618									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Albert R Graf						April 20 1969		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		March 31, 1900		69 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Wisconsin		U.S.A.				Montgomery Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		3502 Chiswick Court			Economist - Dept. of Agriculture				
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				3502-Chiswick Court	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry Graf			Amelia Frohmader						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> WWI					(Wife) Helen L. Graf - 3502 Chiswick Ct., Silver Spring, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Atelectasis									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) Pneumonia & Cerebral Thrombosis									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Carcinoma of Pancreas									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12/4 1968, to 4/19 1969, that (I) (we) last saw the deceased alive on 4/16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert A. Barnett					22c. DATE SIGNED 4/20/69				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Robert A. Barnett									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Apr. 23, 1969		Cedar Hill Cemetery		Suitland, Maryland			
Funeral Director		Funeral Director		Funeral Director		Funeral Director			
Warner E. Pumphrey, Inc.		Silver Spring, Md.		8434 Georgia Avenue		APR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05624

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05619

Item 23 Film G412 5/9/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Baby Girl Graham						April Month 28 Day 1969 Year			3:45 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN
FEMALE		Negro		4/28/69		— YRS.				30
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Olney			Montgomery General Hosp.			none				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Montgomery		Rockville			301 N. Adams st., apt. 29		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
						Rita Diane Graham				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT			Address	
no					none	Records			Montgomery General Hospital, Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, brain pneumonia, pleurisy</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia, pleurisy, brain pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia (3 lb 12 oz)</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>30 min</i> <i>30 min</i> <i>30 min</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Concurrent Cataracts</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/28/69</i> , to <i>4/28/69</i> , that (I) (we) last saw the deceased alive on <i>4/28/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<i>Charles H. Ligon</i>									4/29/69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
Charles H. Ligon, M.D.					Sandy Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		4/28/69		Hunter Laboratory		Washington, D.C.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
							MAY 1 1969		<i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05625

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05620

1. DECEASED NAME (Type or print) First Middle Last Cornelia Isabelle Griffith			2a. DATE OF DEATH Month Day Year April 18 1969		2b. HOUR P 6:30
3. SEX Female	4. RACE White		5. DATE OF BIRTH Sept. 7, 1877		6. AGE (In years last birthday) 91 YRS.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Laytonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last John Thomas Warfield		15. MOTHER'S MAIDEN NAME First Middle Last Rachel V. Dorsey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 213-38-1071		17. INFORMANT Address Records of Montgomery General Hospital, Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS DUE TO, OR AS A CONSEQUENCE OF (b) A.I.A. DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) arteriosclerosis - infarcts, pulmonary, multiple					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1969 to Apr 18 1969 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE Jack Schumacher		DEGREE M. D.		22c. DATE SIGNED 4-20-69	
22d. PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.		22e. ADDRESS 105 Russell Ave., Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-22-69		23c. NAME OF CEMETERY OR CREMATORY Goshen	
24. FUNERAL DIRECTOR Francis H. Barber		ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR APR 23 1969	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05626

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05621

1. DECEASED-NAME (Type or print) Jacob			First Middle Last			2a. DATE OF DEATH Month April Day 2 Year 1969			2b. HOUR 1:30 M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH April 19, 1883			6. AGE (in years last birthday) 85 YRS.		
7a. BIRTHPLACE (State or foreign country) Russia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH MONTGOMERY COUNTY Md.		
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) POTOMAC VALLEY NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Foreman			12b. KIND OF BUSINESS OR INDUSTRY Clothing Factory		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE Maryland			13b. COUNTY Bethesda			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Nachman			First Middle Last			15. MOTHER'S MAIDEN NAME Terna			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212-01-8705			17. INFORMANT Mrs Joseph Lieberman			Address 6605 Selbirk Drive		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, liver lung DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of esophagus primary DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 1 year 2 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC HEART DISEASE											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) —			21f. LOCATION Street or R.F.D. No. City or Town County State APRIL					
22a. I certify that (I) (this hospital) attended the deceased from February 20, 1969 , to MARCH 28, 1969 , that (I) (we) saw the deceased alive on MARCH 28, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Yes											
22b. SIGNATURE Stanley J. Talpers MD						22c. DATE SIGNED 4-2-69					
22d. PHYSICIAN'S NAME (Type) STANLEY J. TALPERS						22e. ADDRESS 2141 K ST. NW. WASH D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 6/69			23c. NAME OF CEMETERY OR CREMATORY Isaac Israel			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Joe Hunson						25a. REC'D BY REGISTRAR APR 9 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		



Dr. Selden Roop, Medical Examiner was notified concerning circumstances of this case and he authorized me to sign this certificate on April 5, 1969.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expeditiously filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05627

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05628

1. DECEASED-NAME (Type or print) Emma H. Hackworth			2a. DATE OF DEATH Month April Day 5 Year 69			2b. HOUR 7:15 M					
3. SEX F		4. RACE White		5. DATE OF BIRTH Sept. 27, 1900		6. AGE (in years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12608 PARKLAND DR	
14. FATHER'S NAME First Middle Last W. B. Baucum			15. MOTHER'S MAIDEN NAME First Middle Last Lena			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)					
16b. SOCIAL SECURITY NO. 577-52-2335			17. INFORMANT Gloria Lattea - Address Rockville, Md. 4700 Bartram St.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction left ventricle 4100 DUE TO, OR AS A CONSEQUENCE OF: (b) Atherosclerosis, coronary arteries. DUE TO, OR AS A CONSEQUENCE OF: (c) Hypertensive Heart Disease Undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Abetal Hemia, Diverticulosis of Colon, Atherosclerosis, Cerebral Vascular Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDINGS, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from JULY 19 67 , to APRIL 5, 1969 , that (I) (we) last saw the deceased alive on APRIL 2 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE George L. Ball				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED APR 5 1969			
22d. PHYSICIAN'S NAME (Type) George L. Ball				22e. ADDRESS 10620 Georgetown Rd. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR APR 10 1969				25b. REGISTRAR'S SIGNATURE Charles J. Jones			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 4122a Division of Vital Records, 301 W. Preston Street, Baltimore, Maryland 21201

05628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05623

1. DECEASED-NAME (Type or Print) Lois GAIL HAHN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> April 28 1969			2b. HOUR 1:15 PM			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 3/21/42	6. AGE (In years last birthday) 27 YRS	IF UNDER 24 HRS MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN. 0	2c. DATE PRONOUNCED DEAD Month April Day 28 Year 1969	2d. HOUR 9:17 AM
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			Md.
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if not in institution) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8705 POST OAK RD	
14. FATHER'S NAME First SAMUEL Middle A Last HILLMAN			15. MOTHER'S MAIDEN NAME First JEANETTE Middle SEGAL Last SEGAL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT HUSBAND - PETER HAHN			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PERMANENT Barbiturate poisoning DUE TO, OR AS A CONSEQUENCE OF (b) Overdose of Tuinal DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 12:15 PM 4/28 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Took overdose of Tuinal					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. 8705 Post Oak Rd.		City or Town Rockville		County Montg.	
State Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE G. B. Bell			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED April 28, 1969	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/29/69		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden			23d. LOCATION (City or Town) (County) (State) Falls Church, Va.		
24. FUNERAL DIRECTOR Bernard Danzansky & Sons				ADDRESS 3501 14th St., N. W., Wash., D.C.		25a. REC'D BY REGISTRAR DATE MAY 2 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 145
45M - 1X69

05629										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05624																													
1 DECEASED NAME (Type or print)										2a DATE OF DEATH										2b HOUR																													
First AMY Middle ESTELLE Last HANLEIN										Month 4 Day 3 Year 69										8:13 p.m.																													
3 SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH Dec. 27, 1891										6 AGE (In years last birthday) 77 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN									
7a BIRTHPLACE (State or foreign country) WASHINGTON, D.C.										7b CITIZEN OF WHAT COUNTRY? USA										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH MONTGOMERY COUNTY Md																			
10 CITY OR TOWN OF DEATH TAKOMA PARK, MD.										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, name of place of death) WASH. SANITARIUM & HOSPITAL										12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) AT HOME										12b KIND OF BUSINESS OR INDUSTRY ----																			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD.										13b COUNTY MONTGOMERY										13c CITY OR TOWN TAKOMA PARK										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER 7777 MAPLE AVENUE									
14 FATHER'S NAME First JOHN Middle F. SULLIVAN Last										15 MOTHER'S MAIDEN NAME First ELENORA Middle DANTE Last																																							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NONE										16b SOCIAL SECURITY NO. (If yes give year or dates of service) 213-54-9380										17 INFORMANT ISADORE HANLEIN, SAME AS # 13																													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (his hospital) attended the deceased from <u>3/12</u> , 19 <u>62</u> , to <u>4/3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.																																																	
22b. SIGNATURE <u>RC Kirchner MD</u>										22c. DATE SIGNED 4-4-69																																							
22d. PHYSICIAN'S NAME (Type) Raymond C. Kirchner, MD										22e. ADDRESS 6480 New Hampshire Ave., Tak. Park, Md.																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 4/7/1969										23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY										23d. LOCATION (City or Town) (County) (State) BLADENSBURG, MARYLAND																			
24. FUNERAL DIRECTOR Joseph Sawler Inc.										25a. REC'D BY REGISTRAR APR 7 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													



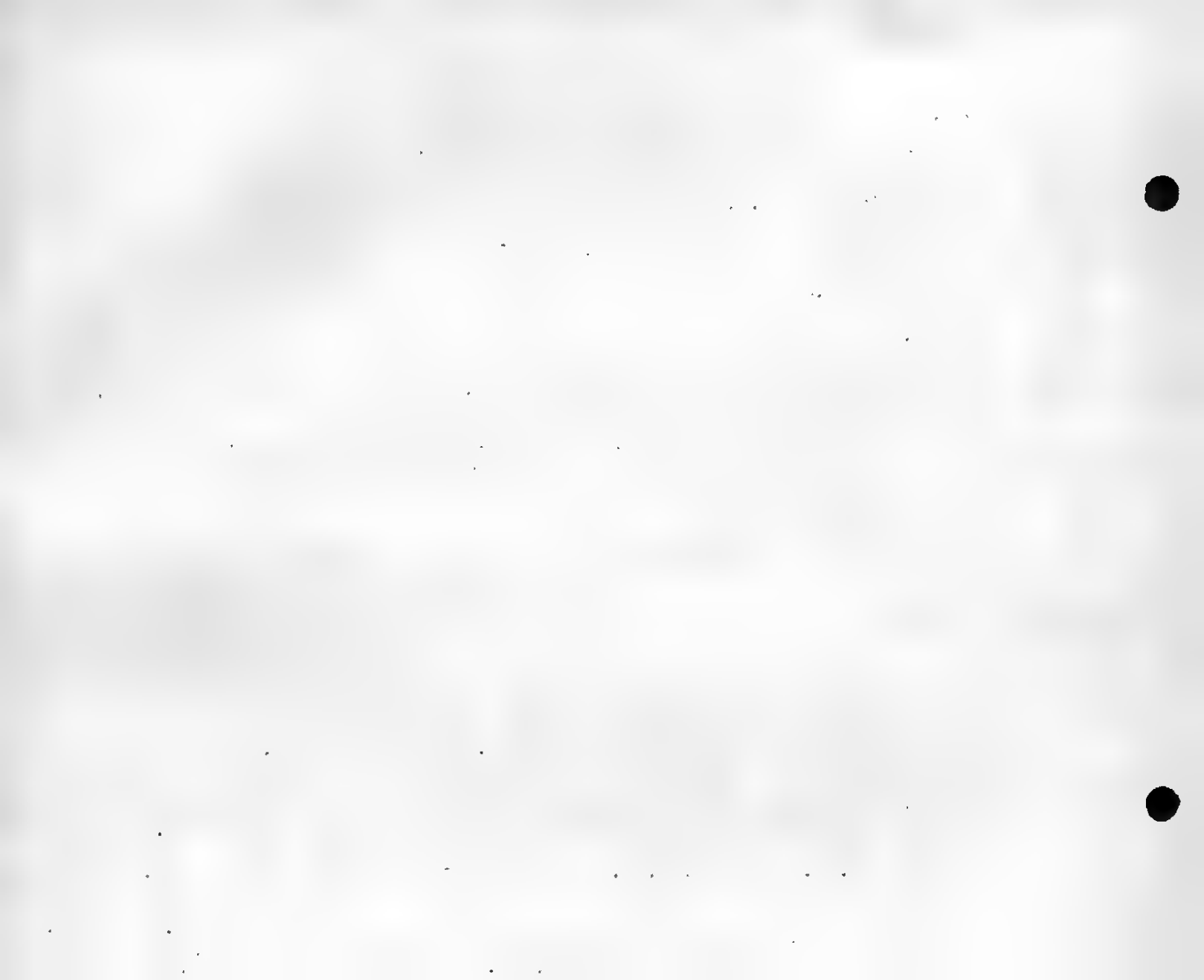
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div>05630</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>05625</div>																	
1. DECEASED NAME (Type or print)			First Virginia			Middle Blunt			Last HARMON			2a. DATE OF DEATH April Month 15 Day 1969			2b. HOUR 1247 P M		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH June 20, 1919			6. AGE (In years last birthday) 49 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md								
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY N/A								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Florida			13b. COUNTY Monroe			13c. CITY OR TOWN Summerland Key			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Box 78					
14. FATHER'S NAME First Joseph			Middle Blunt			15. MOTHER'S MAIDEN NAME First Anna			Middle Spaulding			Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) No			16b. SOCIAL SECURITY NO. 578 12 6824			17. INFORMANT Roy L. Harmon, Box 78 Summerland Key, Fla			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Post operative repair of atrial septal defect</u>																	
DUE TO, OR AS A CONSEQUENCE OF <u>with acute dissection of aorta</u>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION 15 Apr 69			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atrial septal defect			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A M Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Mar. 25</u> , 19 <u>69</u> , to <u>Apr. 15</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Apr. 15</u> , 19 <u>69</u> and that in <u>(xx)</u> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death																	
22b. SIGNATURE <i>H. E. Ashworth</i>			DEGREE H. E. ASHWORTH, M. D.			ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED Apr. 17, 1969								
22d. PHYSICIAN'S NAME (Type) H. E. ASHWORTH, M. D.			22e. ADDRESS Naval Hospital, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-21-69			23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington Arlington VA.								
24. FUNERAL DIRECTOR Everly-Wheatley Funeral Home			1500 West Braddock Road, Alexandria, Va.			25a. REC'D BY REGISTRAR APR 22 1969			25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>								

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

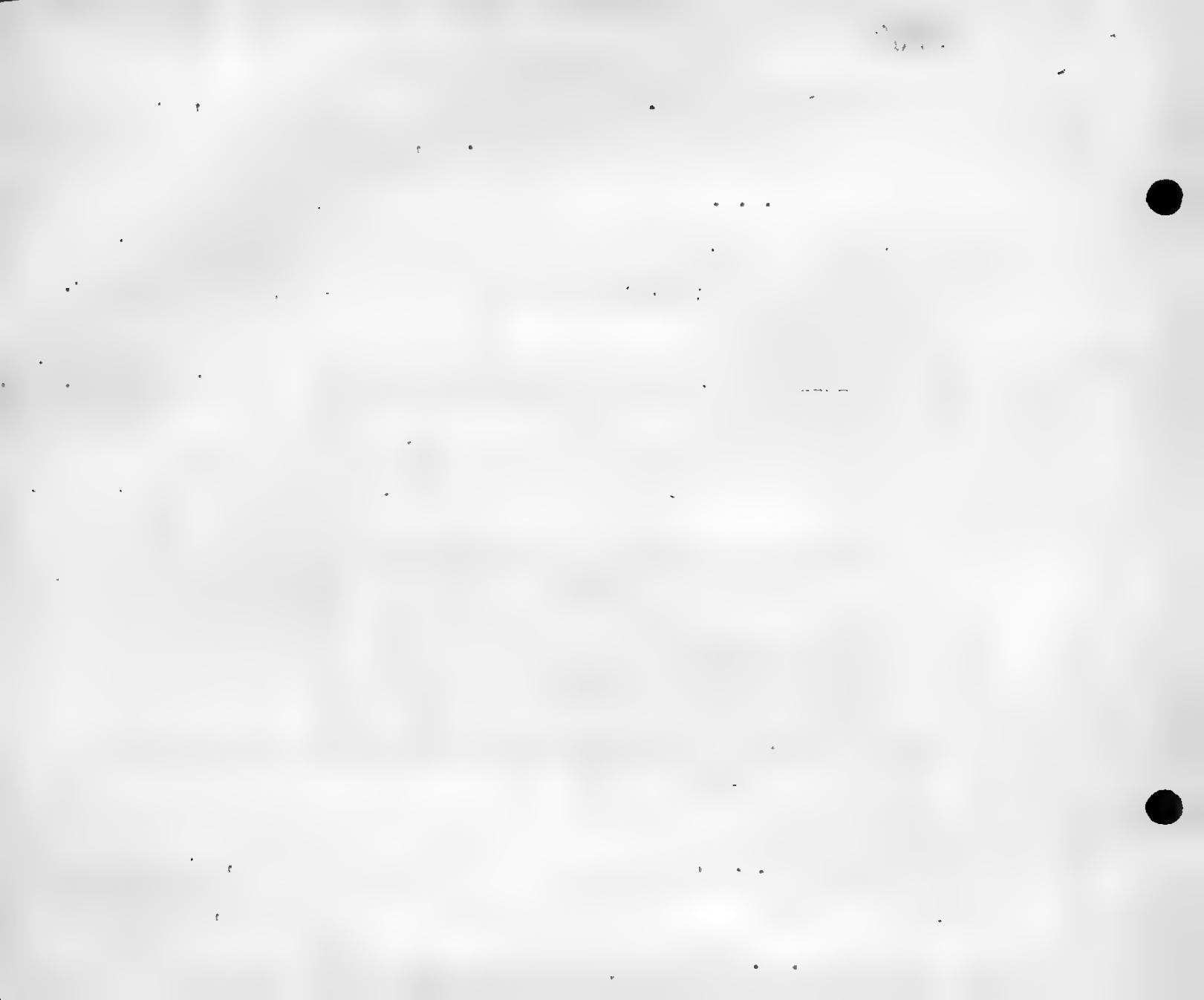
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05631		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05626	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR
Peant			Gertrude	HARRINGTON	April 19 69		8:30 AM
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS
Female	White		MAR. 20, 1886		83 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
MARYLAND		U.S.A.				Montgomery Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		2407 GLEN ALLEN AVE.		HOUSEWIFE		AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Montgomery		Silver Spring		2407 GLEN ALLEN AVE.	
14. FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last					
CHARLES F. LITTLE		MARGARET - BENNETT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address			
NO		578-36-3601		CAMILLE SHERMAN CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>1 yr.</u> <u>4 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 12, 1969</u> , to <u>4/19, 1969</u> , that (I) (we) last saw the deceased alive on <u>4/18, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Raymond T. Benack MD</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/19/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>				22e. ADDRESS <u>4115 Colie Dr. Wheaton, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		4/22/69		ROCK CREEK CEM.		WASHINGTON, D.C.	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, 5130 WISCONSIN AVE. WASHINGTON, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 23 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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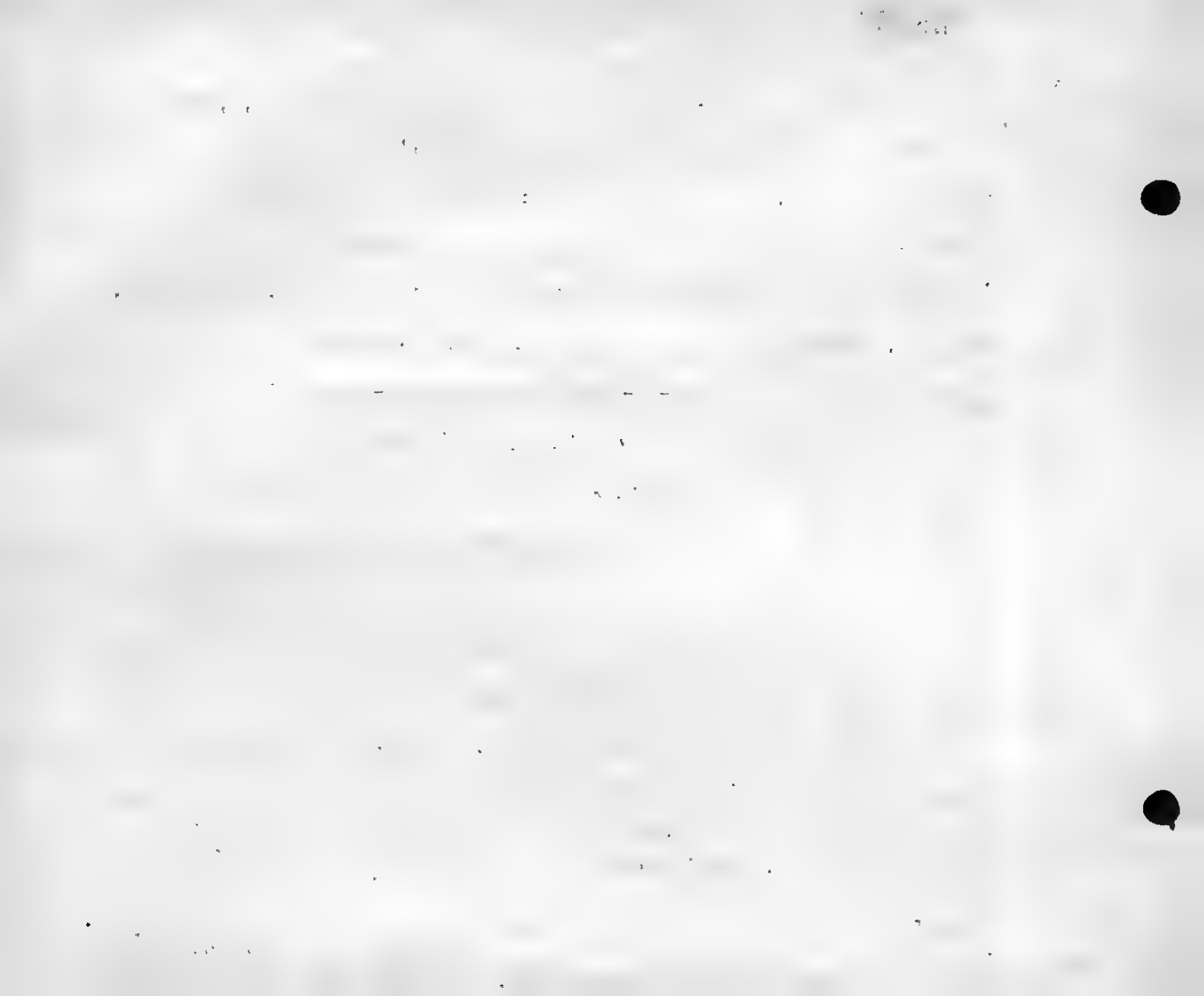
05632		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05627	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Arnold E. Harris			2a. DATE OF DEATH Month Day Year April 5, 1969		2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Aug. 17, 1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Tobey Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 12819 Twinbrook Pkwy.							
14. FATHER'S NAME First Middle Last William Harris			15. MOTHER'S MAIDEN NAME First Middle Last Minnie Harrington				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 403 05 3270		17. INFORMANT Address Maryland Carl Harris - son - 512 College Pkwy. Rock			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 5, 1969</u> to <u>April 5, 1969</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Edward J. Richards</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 4-6-69			
22d. PHYSICIAN'S NAME (Type) Edward J. Richards				22e. ADDRESS 1010 Georgia Avenue, Silver Spring, Md			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 4/8/69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler F. H. 1331 Rockville Pike Rockville, Maryland				25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE <u>Charles J. J. J.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05633		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05628	
Item #11 FilrGL11 4/18/69 km							
1. DECEASED-NAME (Type or print) ERNEST L. HARTMAN				2a. DATE OF DEATH Month April , Day 7 , Year 1969		2b. HOUR 6A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 10, 1883		6. AGE (in years last birthday) 85 YRS	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR NURSITUTION (If not in hospital give street address) 1331 1/2 Van Buren St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 125 S. VanBuren St.							
14. FATHER'S NAME First Middle Last George P. Hartman				15. MOTHER'S MAIDEN NAME First Middle Last Sue Kate Eicholtz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 188-12-3684A		17. INFORMANT Address Herman Hartman-Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 4350 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) LONG STANDING ESSENTIAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 26 YEARS 25 YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 1968 , to April 7, 1969 , that (I) (we) last saw the deceased alive on April 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gordon S. Rosenberger		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 7, 1969	
22d. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		22e. ADDRESS 31 West Montgomery Ave Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/10/69		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem		23d. LOCATION (City or Town) (County) (State) Arendtsville Pa.	
24. FUNERAL DIRECTOR Tyson Wheeler				ADDRESS Funeral Home 1331 Rockville		25a. REC'D BY REGISTRAR April 11 1969	
						25b. REGISTRAR'S SIGNATURE Charles Judge	
Rockville, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

05634

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05629

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Ruth NMN Havens			2a. DATE OF DEATH 4 Month 10 Day 1969 Year		2b. HOUR 6:50 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 2-25-89		6. AGE (in years lost birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery			Md.		
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher	
12b. KIND OF BUSINESS OR INDUSTRY Teaching					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Ashton	
14. FATHER'S NAME First Middle Last James J. Shoemaker		15. MOTHER'S MAIDEN NAME First Middle Last Helen Reese			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. -		17. INFORMANT Records of: Montgomery General Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforation of Colon DUE TO, OR AS A CONSEQUENCE OF (b) Measenteric thrombosis (post Surg) DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 h - 6 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 4/4/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstruction due to C. of Colon		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/4 , 19 69 , to 4/10 , 19 69 , that (I) (we) last saw the deceased alive on 4/10 , 19 69 , and that in (my) (us) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE [Signature]		22c. DATE SIGNED 4/11/69		22d. PHYSICIAN'S NAME (Type) Dr. Charles H. Lison M.D.	
23a. BURIAL-CREATION, REMOVAL (Specify) 4/11/69		23b. DATE 4/11/69		23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home	
23d. LOCATION (City or Town) (County) (State) Wash. D.C.		24. FUNERAL DIRECTOR Francis H. Barlow Laytonsville Md.		25a. REC'D BY REGISTRAR APR 18 1969	
25b. REGISTRAR'S SIGNATURE [Signature]					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared to be Crowned

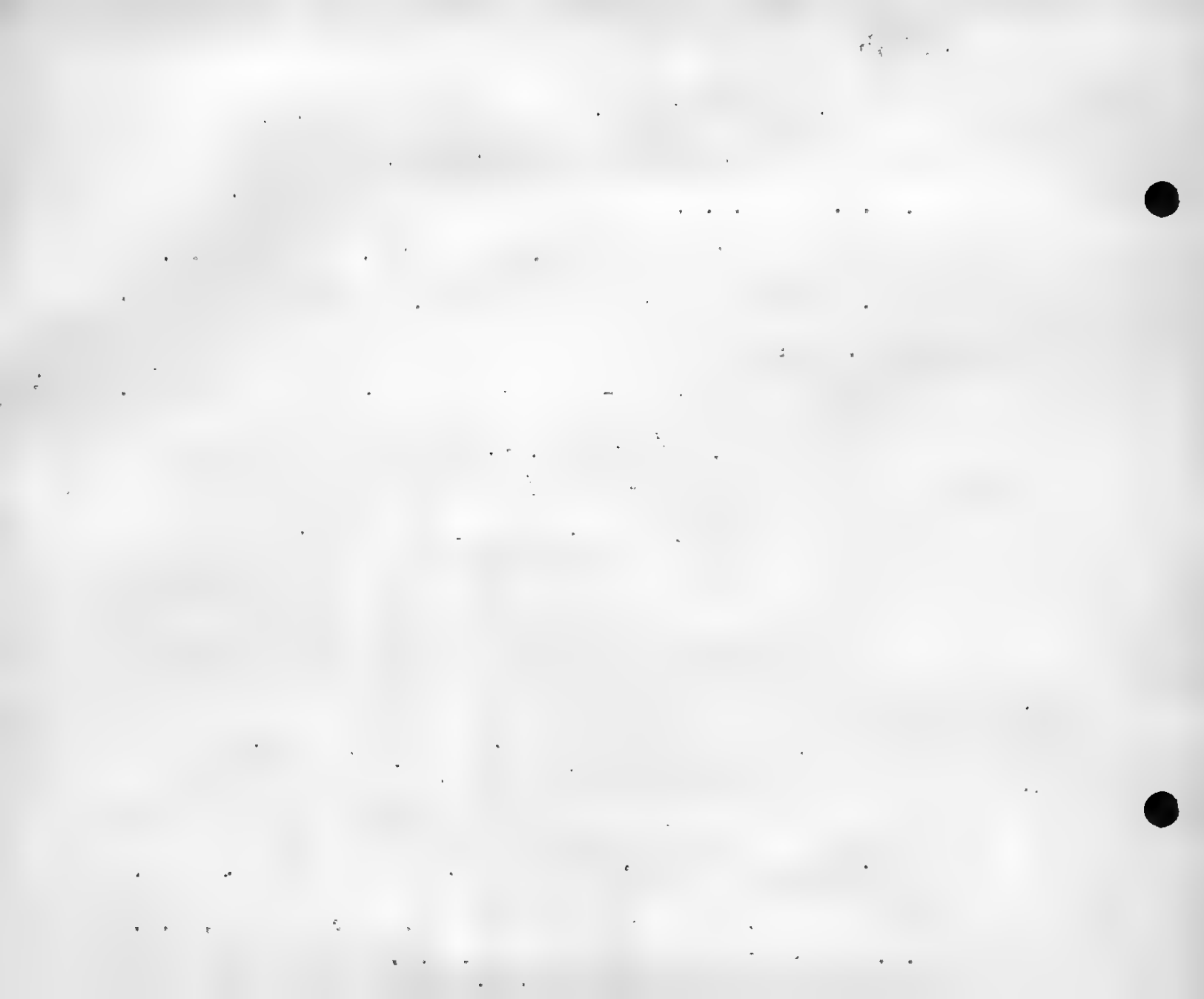
05635

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05630

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) LEONARD MEREDITH HAYS			2a. DATE OF DEATH Month 4 Day 7 Year 1969			2b. HOUR 1:30 PM			
3 SEX male		4 RACE white		5. DATE OF BIRTH 11/29/11		6 AGE (In years lost birthday) 57 YRS		7 UNDER 1 YEAR MONTHS 0 DAYS 0	
7a BIRTHPLACE (State or foreign country) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8715 1st Ave.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Lept. of Labor-U.S. Government		12b. KIND OF BUSINESS OR INDUSTRY Government			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8715 1st Ave.	
14 FATHER'S NAME Bernard F. Hays			15. MOTHER'S MAIDEN NAME Mary Elizabeth Maddox						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. 577-54-7492		17 INFORMANT Charles Hays-1136 Hornell		Address Spring, Md. Dr. Silver			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH miss. 1 day years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from May , 19 67 , to April , 19 69 , that (I) (we) last saw the deceased alive on 4/8 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Harold W. Draper M.D.		22c. DATE SIGNED 4/7/69		22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.		22e. ADDRESS 9801 Georgia Ave, Silver Spring, Md			
23a BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/10/69		23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR The S.H. Hines Company		25a. REC'D BY REGISTRAR N. APR 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers numbered 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05636		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05631	
Item 6 Film 412 5/9/69 kk							
1. DECEASED NAME (Type or print) First Middle Last SISTER LOYOLA HEALY				2a. DATE OF DEATH Month Day Year April 29 1969		2b. HOUR 4:45 PM	
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 7/4/88		6. AGE (In years last birthday) 80 YRS.	
7a. BIRTHPLACE (State or foreign country) BETHESDA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Timothy Healy		15. MOTHER'S MAIDEN NAME First Middle Last Margaret McBreedy		13e. STREET AND NUMBER 9600 Forest Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO Yes		17. INFORMANT CONVERT RECORDS 9600 Forest Rd. Beth. Md.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral thrombosis 4501 DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10da 4 yrs 2	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral arterio-sclerotic disease.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1949, 19, to 4/29, 1969, that (I) (we) last saw the deceased alive on 4/28/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard J. Walsh M.D.				22c. DATE SIGNED 4/29/69			
22d. PHYSICIAN'S NAME (Type) Bernard J Walsh Md				22e. ADDRESS 1800 Eye St N.W. - D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-2-69		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md				25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE H. C. ...	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 413 MARYLAND STATE DEPARTMENT OF HEALTH
5-13-69 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05632

05637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			Month Day Year			2b. HOUR		
Thomas Anthony Hessian						4-9-69			5:35M					
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years reg'd & thday)	IF UNDER YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR			
M	W	2-27-28	41 YRS	MONTHS DAYS		HOURS MIN.		Month Day Year			5:35M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Md.		US				Montgomery Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park			Washington San & Hosp			Counselor			Employment agency					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY (In 1st)			13e. STREET AND NUMBER		
Md.			Montgomery			Silver Springs			YES <input type="checkbox"/> NO <input type="checkbox"/>			816 Easley St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
William P Hessian			Mary Hughes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT								
Yes			1948 to 1952			Dora J Hessian								
			216 24 7522			Hyattsville, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive cerebral vascular hemorrhage												1 day		
887X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) Accidental head injury												1 day		
(c) Fell in home														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			4-9-69 P.M.			Fell at home								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State								
			Home			816 Easley St Hyattsville Md								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED					
John W. Roger									4-9-69					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR REPOSITORY			23d. LOCATION (City or Town) (County) (State)						
Burial			April 14, 1969		Punch Bowl National			Honolulu Honolulu Hawaii						
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Francis Gasch's Sons			Hyattsville Md.			APR 15 1969			Nicholas Judge					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05638

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05633

1. DECEASED NAME (Type or Print) <i>Vernon</i> First <i>S</i> Middle <i>Hill</i> Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>4</i> Day <i>7</i> Year <i>1969</i>			2b. HOUR <i>1:53</i> M		
3 SEX <i>Male</i>	4 RACE <i>Negro</i>	5 DATE OF BIRTH <i>7/14/1898</i>	6 AGE (In years last birthday) <i>70</i> YRS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month <i>April</i> Day <i>7</i> Year <i>1969</i>			2d. HOUR <i>1:53</i> M
7a. BIRTHPLACE (State or foreign country) <i>Montgomery</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Ind.</i>			13b. COUNTY <i>Mont.</i>			13c. CITY OR TOWN <i>Rockville</i>		
14. FATHER'S NAME First <i>Vernon</i> Middle <i>S</i> Last <i>Hill</i>			15. MOTHER'S MAIDEN NAME First <i>Bessie</i> Middle <i>J</i> Last <i>Johnson</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS: <i>Wife, Mabel Hill, Same as above</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio Vascular Disease -</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2</i> <i>years</i>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John S. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>APR 17, 1969</i>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4-10-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Park Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville Montg Md.</i>		
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>				ADDRESS <i>Rockville Md.</i>		25a. REC'D BY REGISTRAR <i>APR 14 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

05639										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05634									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last Hannah Hopper										Month Day Year 4 6 1969										2:50 PM									
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH Jan 30, 1887			6. AGE (In years last birthday) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN														
7a. BIRTHPLACE (State or foreign country) N.Y.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery County Md.																				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 8600 16th St. Silver Spring																	
14. FATHER'S NAME First Middle Last LOUIS GOLD			15. MOTHER'S MAIDEN NAME First Middle Last Unknown																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 231-26-5833-A			17. INFORMANT Dr. Herbert M. Hoffer			Address 8309 Raymond Lane Potomac, Maryland																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>POST-OPERATIVE FRACTURE RIGHT HIP, OLD MYOCARDIAL INFARCTION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HOURS 4-5 YRS																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (the hospital) attended the deceased from <u>FEB</u> , 19 <u>67</u> , to <u>APRIL 6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>APRIL 6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Edward A. Beeman M.D.			22c. DATE SIGNED APRIL 6, 1969			22d. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN			22e. ADDRESS 1015 SPRING ST. SILVER SPRING, MD 20910																				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE April 8, 1969			23c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery			23d. LOCATION (City or Town) (County) (State) Norfolk Virginia																				
24. FUNERAL DIRECTOR Donald M. Stein			ADDRESS 232 Carroll			25a. RECEIVED BY REGISTRAR APR 9 1969			25b. REGISTRAR'S SIGNATURE J. Charles Judge																				
Hebrew Memorial Funeral Home St., N.W. Wash., D.C.																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

05640		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05635			
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
William Hoffman						April 4 1969		8:30 AM	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		Nov. 3, 1891		77		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		U.S.A.				Montgomery Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Wheaton		12404 Livingston St.		Welder (Ret.)					
13a USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
New Jersey				Camden				827 Morgan Street	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
unknown						unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17. INFORMANT				Address
No			150-10-1909A		Mrs. Elizabeth Thompson				Wheaton, Md. 12404 Livingston St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion									2 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) Arteriosclerotic Heart Disease									years
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb 23 1969, to April 4 1969, that (I) (we) last saw the deceased alive on April 4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE			22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		22e DATE SIGNED	
John J. Curry			John J. Curry			8801 Georgia Ave., Silver Spring, Md.		4/4/69	
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Apr. 8, 1969		New St. Mary's Cemetery		Belmar New Jersey		
24. FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Warner E. Humphrey, Inc.			8434 Georgia Avenue Silver Spring, Md.			APR 11 1969			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05641

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05636

1 DECEASED-NAME (Type or print) <i>Varona B Holman</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>11</i> Year <i>1969</i>			2b. HOUR <i>11:50</i> <i>PM</i>					
3 SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>11/16/1886</i>		6. AGE (In years last birthday) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>South Dakota</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County</i> Md					
10. CITY OR TOWN OF DEATH <i>Silver Spring, Maryland</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Colonial Villa Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>School Teacher</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY L.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>641-5110 Ave.</i>		
14 FATHER'S NAME First <i>George J.</i> Middle <i>Brenner</i> Last <i>Brenner</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Walter</i> Last <i>Walter</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO <i>494-30-454</i>		17. INFORMANT <i>William B Holman</i> Address <i>641-5110 Ave Silver Spring, Md</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular thrombosis</i> <i>4124</i> DUE TO OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Isolated widespread metastatic carcinoma</i>											
19a. DATE OF OPERATION <i>-</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>31 March, 1967</i> , to <i>11 April, 1969</i> , that (I) (we) last saw the deceased alive on <i>9 April, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d not) view the body after death.											
22b. SIGNATURE <i>Ernest E Harmon MD</i>					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>11 April 69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Ernest E Harmon MD</i>					22e. ADDRESS <i>9301 Colesville Rd Silver Spring</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>April 16, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Norwegian</i>			23d. LOCATION (City or Town) (County) (State) <i>Mobridge, South Dakota</i>				
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey Inc.</i>					ADDRESS <i>8434 Ga Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 17 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
45M - 1/69

05642		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		05637	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
LORRAINE B HOMER					April 26 1969		5-25 AM
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR	
Female	White		August 29, 1908		60 YRS.	MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Washington D.C.		U.S.A.				MONTGOMERY Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		Suburban Hosp		CLERK		N I H	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND		Montgomery		Bethesda		5818 Greentree Rd.	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
JESSE LEE BUNCH					MARY ALICE HURTT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address	
No				577-48-4416		Charles H. HOMER Jr.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1830 Coma							18 MYS
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma ovary							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory office building, etc)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 31, 1964, to April 26, 1969, that (I) (we) last saw the deceased alive on April 25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
EDGAR H. LEVIN M.D.				4/26/69			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
EDGAR H. LEVIN				8218 Wisconsin Ave. Bethesda			
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		4-29-69		Rock Creek		Washington, D.C.	
24. FUNERAL DIRECTOR Robert A. Pumphrey				25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE	
7557-Wisconsin Ave., Bethesda, Md.				MAY 5 1969		Charles Judge	

MEDICAL CERTIFICATION

Classified with Medical Exemption

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

05643		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05638		
CERTIFICATE OF DEATH								
1 DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR
MICHAEL JOSEPH HORKAN						April 8, 1969		3:25 PM
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Male		White		January 16, 1889		80 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
England		USA				Montgomery Md.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park		Wash. San. & Hosp.		Mail Clerk				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.		Mont.		S.S.				8112 Tahona Dr.
14 FATHER'S NAME First Middle Lost			15 MOTHER'S MAIDEN NAME First Middle Lost					
Michael Horkan			Mary Griffin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (Type or unknown) None (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address			
					Hospital Chart			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion								
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Arteriosclerosis generalized								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
Bronchopneumonia + Emphysema Pulmonary								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 4/7, 1969, to 4/8/69, that (I) (we) saw the deceased alive on 4 Apr 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
Thomas P. Fogarty		8 Apr 69						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
THOMAS P. FOGARTY		SILVER SPRING BLVD. EAST, SILVER SPRING, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		4-12-69		GARDEN OF EDEN		SILVER SPRING, MARYLAND		
24. FUNERAL DIRECTOR FRANCIS J. COLLINS ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
3000 UNIVERSITY BLVD. SILVER SPRING, MD.				APR 15 1969		Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil at Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form RMC-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>05644</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05639</div>											
1. DECEASED NAME (Type or Print)			First John			Middle H.			Last Hossman		
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH 3/12/1875		6. AGE (in years) 94		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Wisconsin			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital) University Nur. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Montg.			13c. CITY OR TOWN Sil. Spr.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Johann			Middle Hossman			Last Wilhelmina			15. MOTHER'S MAIDEN NAME First ?		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Spanish Amer.			16b. SOCIAL SECURITY NO. 393-03-9065			17. INFORMANT Mrs. Ruth Voss, 1701 Sherwood Rd.			ADDRESS Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 41 - Acute Coronary Insufficiency Arteriosclerotic Heart Disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED April 4, 1969			
EXAMINER'S NAME (Type) Belden R. Reap, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, State) Wheaton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 8, 1969			23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Cemetery Menomonee Wisconsin			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR Paul J. Smith & Sons 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.						25a. REC'D BY REGISTRAR APR 11 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A) 45M 1969

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05645 CERTIFICATE OF DEATH 05640									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Mary M. Hottinger						Apr 13 1969			10 48 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		Sept. 22, 1883		85 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Va.		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INST. TUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Germantown			The Marylander			H. Wife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if inst. tution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Mont.		Boyd		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #1 Box 265A
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Frederick Lowry			Frances Emily Lowry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT				
no			-		Mr. Lester Hottinger Washington Grove, Md.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Parkinson's Disease</u>									13 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Cerebral Arteriosclerosis</u>									years
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Cystitis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12 Aug. 1960</u> , to <u>13 April 1969</u> , that (I) (we) saw the deceased alive on <u>11 April 1969</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Gordon Murdoch Smith, M.D.</u>						22c. DATE SIGNED <u>13 April 69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Gordon Murdoch Smith</u>						22e. ADDRESS <u>Barnesville, Maryland 20703</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			4-16-69		St. Lukes		Redland Mont. Md.		
24. FUNERAL DIRECTOR <u>Francis H. Barber Laytonsville, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 18 1969</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

05646		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05646	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) First Middle Last <i>Martin John Hudtloff</i>			2a. DATE OF DEATH Month Day Year <i>April 6 1969</i>			2b. HOUR <i>12</i> M	
3. SEX <i>male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>11/10/02</i>		6. AGE (in years last birthday) <i>66</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Montana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Relief</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <i>MARTIN DAVID HUDTLOFF</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>JULIA - DETLOFF</i>		13e. STREET AND NUMBER <i>7916 S. ...</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>W.W. II 317-44-0247</i>		17. INFORMANT <i>SON MARTIN HUDTLOFF - Arlington Va</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>most</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>arricular fibrillation</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immed</i> <i>immed</i> <i>10 days</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 27 1969</i> , to <i>Apr 6 1969</i> , that (I) (we) last saw the deceased alive on <i>March 27 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.R. E. Hermanhart MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>4/6/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>W.R. E. Hermanhart</i>				22e. ADDRESS <i>4125 Rockville Pike Rockville</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4/9/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT. CEM</i>		23d. LOCATION (City or Town) (County) (State) <i>ARLINGTON VA</i>	
24. FUNERAL DIRECTOR <i>JOSEPH GANLERS SONS, 5130 WIS. AVE. N.W. WASHINGTON D.C.</i>				25. PREPARED BY REGISTRAR <i>APR 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05647
CERTIFICATE OF DEATH
0564

1. DECEASED-NAME (Type or print) Kathryn Sadie Hunter			2a. DATE OF DEATH Month April Day 24 Year 1969			2b. HOUR 7:55 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1 December 1968		6. AGE (In years lost birthday) YRS. 4 MONTHS 23 DAYS 23 HOURS 55 MIN		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Child		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13b. COUNTY Athens		13c. CITY OR TOWN Athens		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 712 Wells Avenue	
14. FATHER'S NAME First Middle Last Duane Hunter			15. MOTHER'S MAIDEN NAME First Middle Last Norleene Lantz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Bethesda, Maryland 20014 The Medical Records, The Clinical Center,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brachycardia 1466 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypoplastic left heart syndrome DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Minutes 4 Months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION 4/23/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Atresia of Aortic Arch/		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that Dr. (this hospital) attended the deceased from 14 April, 1969 , to 24 April, 1969 , that Dr. (we) last saw the deceased alive on 24 April, 1969 , and that in 1 day (our) opinion death occurred on the date and hour and from the causes stated above Dr. (we) (did) (did not) view the body after death.									
22b. SIGNATURE Michael A. Berman, M.D.				22c. DATE SIGNED 24 April 1969		22d. PHYSICIAN'S NAME (Type) Michael A. Berman, MD.			
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-28-69		23c. NAME OF CEMETERY OR CREMATORY W.C. Chambers Co		23d. LOCATION (City or Town) (County) (State) Athens, Pa.			
24. FUNERAL DIRECTOR W.C. Chambers Co		ADDRESS 1400 E. Chestnut St. D.C.		25a. REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1. This form may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

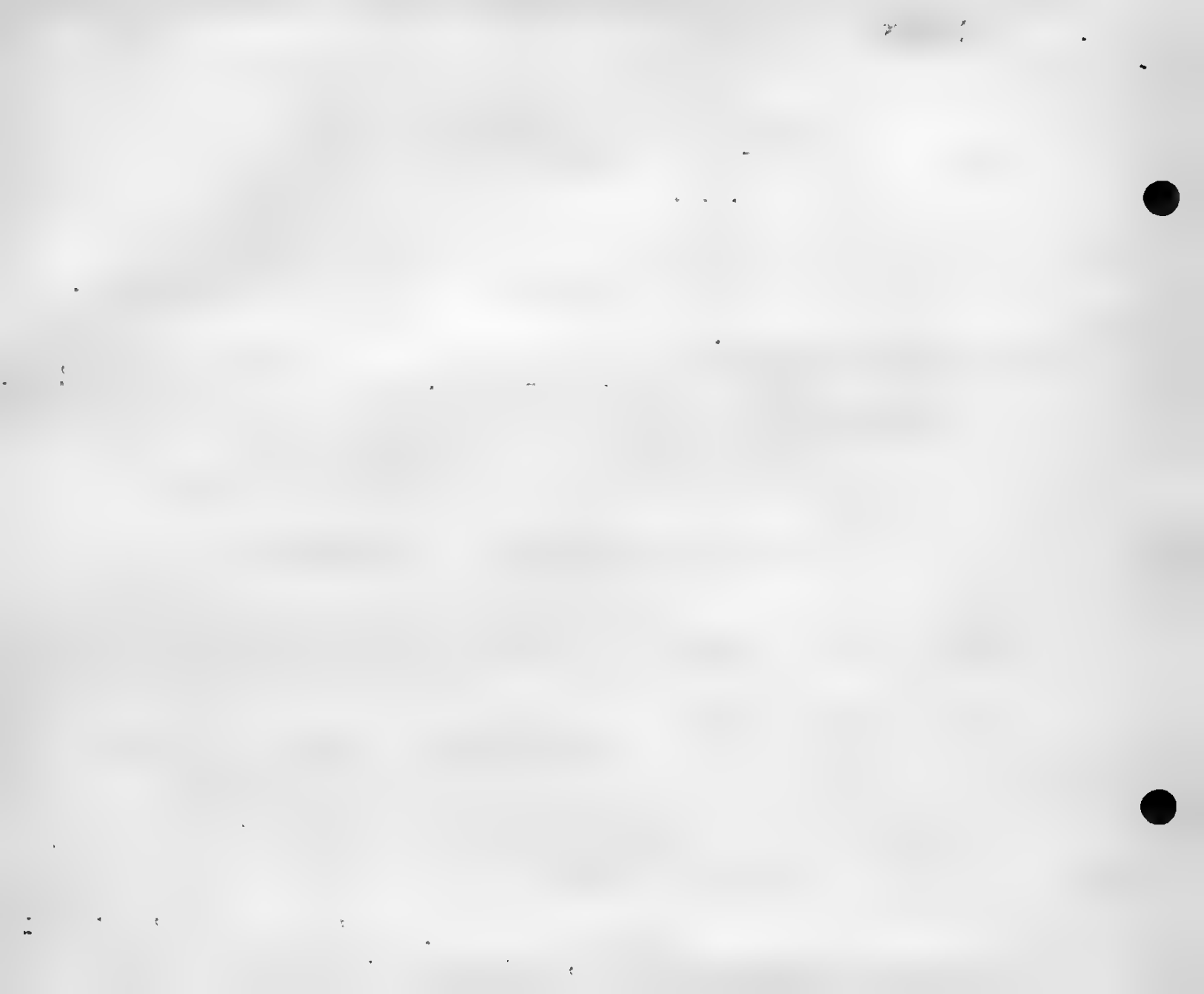
05648

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05643

1. DECEASED NAME (Type or Print) <i>Lucy Margaret Isemann</i>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>4</i> Day <i>8</i> Year <i>69</i>			2b. HOUR <i>6:30</i> AM		
3 SEX <i>Fe</i>	4 RACE <i>Cauc</i>	5 DATE OF BIRTH <i>3-06-89</i>	6 AGE (In years) <i>80</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>4</i> Day <i>8</i> Year <i>69</i>			2d. HOUR <i>6:30</i> AM		
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Randolph Hills Hosp. Home</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>			12b KIND OF BUSINESS OR INDUSTRY <i>***</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>			13b CITY OR TOWN <i>Montgomery</i>		13c INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER <i>4977 Battery Lane.</i>				
14 FATHER'S NAME First <i>Horace</i> Middle <i>P.</i> Last <i>Smith</i>			15 MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Elsea</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b SOCIAL SECURITY NO <i>579-12-7712-D</i>		17 INFORMANT <i>4853 Cornell Avenue, Mrs. Valentine McInteer, Beth. Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4123 Acute Coronary Insufficiency</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Heart Disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Reap</i>		EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						ADDRESS (Street, city, town, county)		22b. DATE SIGNED <i>April 8, 1969</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-11-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery, Bladensburg, Pr. Geo.</i>			23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY,</i>				7557 Wisconsin Ave., Bethesda, Maryland				25a. REC'D BY REGISTRAR <i>APR 15 1969</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05649		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05644	
Item 2a Film 412		5/7/69 kk		CERTIFICATE OF DEATH	
1. DECEASED NAME (Type or print) ERNEST JACKSON			2a. DATE OF DEATH Month April Day 10 Year 69		2b. HOUR M
3. SEX Male		4. RACE Colored	5. DATE OF BIRTH 6-6-1900		6. AGE (In years lost birthday) 68 YRS
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Junk dealer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.		13b. CITY OR TOWN D.C.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET AND NUMBER 2526 8th Street, N.W.		14. FATHER'S NAME First John Middle Jackson Last Jackson		15. MOTHER'S MAIDEN NAME First Clara Middle Terry Last Terry	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Sister Address Mrs. Pearl Coleman-4574 Eads St., N.E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis 150 X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF (c) unf Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unf
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1969 , to Apr 10, 1969 , that (I) (we) lost saw the deceased alive on April 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. G. Hadley		22c. DATE SIGNED 4-11-69		22d. PHYSICIAN'S NAME (Type) Henry G. Hadley, M. D.	
22e. ADDRESS 4601 Nichols Avenue, S.W., Wash. D.C.		23a. BURIAL CREMATION, REMOVAL (Specify) Burial			
23b. DATE 4/16/69		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Maryland	
24. FUNERAL DIRECTOR John T. Stewart		25a. REC'D BY REG. STRAP APR 14 1969		25b. REG. STRAP'S SIGNATURE John T. Stewart	
Stewart Funeral Home-4001 Behning Road, N.E.					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 112 5/6/69k MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05650 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05645

1. DECEASED-NAME (Type or Print) <i>Henry E. James</i>			2a. DATE KNOWN OF EST-DEATH MATED <input checked="" type="checkbox"/> <i>April 26 1969</i>			2b. HOUR <i>4:30 PM</i>		
3. SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>11/1/41</i>	6. AGE (In years last birthday) <i>27</i>	IF UNDER 1 YEAR MONTHS <i>7</i> DAYS <i>18</i>	F UNDER 24 HRS HOURS <i>18</i> MIN <i>25</i>	2c. DATE PRONOUNCED DEAD Month <i>April</i> Day <i>26</i> Year <i>1969</i>		
7a. BIRTHPLACE (State or foreign country) <i>U.S.H.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.H.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Private</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Mont. Gaithersburg</i>			13c. STREET AND NUMBER <i>21st #2</i>		
14. FATHER'S NAME First <i>Henry</i> Middle <i>James</i> Last <i>James</i>			15. MOTHER'S MAIDEN NAME First <i>Freda</i> Middle <i>Eshbaugh</i> Last <i>Eshbaugh</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>22-40-1533</i>			17. INFORMANT ADDRESS <i>Gertrude James / 145 - 14th</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>5400 ACUTE FIBRINO-PURULENT PERITONITIS</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>RUPTURED GANGRENOUS APPENDIX</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>April 27, 1969</i>		
EXAMINER'S NAME (Type) <i>John G Ball</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			ADDRESS (Street, city, town, or county) <i>Bethesda, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 1, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Davis Memorial Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Cumberland, Allegany, Md.</i>	
24. FUNERAL DIRECTOR <i>James F. Scarpelli, Cumberland, Md.</i>				25a. REC'D BY REGISTRAR <i>MAY 1 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. G. Ball</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 1-1-69
30M REV. 1-69

05651

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05646

1. DECEASED-NAME (Type or print) LAURA AURELIA JOHNSON			2a. DATE OF DEATH Month 4 Day 10 Year 1969			2b. HOUR 12:10PM			
3. SEX F		4. RACE Negro		5. DATE OF BIRTH 2-10-1903		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) U. N. HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) R. N.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE D.C.		13b. COUNTY 1		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1339 Otis Place N.W. Wash. DC	
14. FATHER'S NAME First James Middle Johnson Last Johnson			15. MOTHER'S MAIDEN NAME First Sarah Middle Buggs Last Buggs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 577-12-5163		17. INFORMANT Miss C. JOHNSON		Address Same as pt's			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) chronic								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) renal insufficiency									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 315 City or Town 1410 County 1969 State 1969					
22a. I certify that (I) (this hospital) attended the deceased from 4/10/69 to 4/10/69 , that (I) (we) last saw the deceased alive on 4/10/69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James M. Johnson, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/10/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/15/69		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) Maryland		(County) (State)	
24. FUNERAL DIRECTOR Stewart Funeral Home				25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05652 CERTIFICATE OF DEATH 05647									
1. DECEASED-NAME (Type or print) First Middle Last LLOYD EDWARD JONES					2a. DATE OF DEATH Month Day Year APRIL 12 1969				
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH 14 SEPT. 1946		6. AGE (In years lost birthday) 22 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL, BETHESDA		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) USN		12b. KIND OF BUSINESS OR INDUSTRY USN			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2149 HAWKINS POINT RD	
14. FATHER'S NAME First Middle Last LLOYD (NMN) JONES			15. MOTHER'S MAIDEN NAME First Middle Last ALICE PAGE BELL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> (If yes, give dates of service) YES 1 MAR 66 PREST		16b. SOCIAL SECURITY NO. 217 50 9236		17. INFORMANT Address MRS. L. JONES 2149 HAWKINS PT. RD. BALTIMORE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MULT. FRAGMENT WOUNDS OF LEG AND CHEST WITH PERFORATION OF COLON, SMALL BOWEL AND LIVER DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 1 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) BATTLE CASUALTY IN REPUBLIC OF VIETNAM					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 09 MAR 1969 , to 12 APRIL 1969 , that (X) (we) last saw the deceased alive on 12 APRIL 1969 , and that in (MY) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Donald K. Roeder</i>		DEGREE MC		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 13 April 1969			
22d. PHYSICIAN'S NAME (Type) LCDR DONALD K. ROEDER, MC, USN		22e. ADDRESS Naval Hospital BETHESDA, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 17 APRIL 1969		23c. NAME OF CEMETERY OR CREMATORY McGULLY'S Cedar Hill		23d. LOCATION (City or Town) (County) (State) BROOKLYN PARK MD.			
24. FUNERAL DIRECTOR <i>W.H. Chambers Co</i>		ADDRESS <i>1400 Chapel St. NW</i>		25a. REC'D BY REGISTRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05653		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05648	
1 DECEASED NAME (Type or print)		First RUTH	Middle LEWIS	Last JONES	2a DATE OF DEATH Month Day Year 1 12 69		2b. HOUR 1:05 PM
3 SEX Female	4. RACE White	5. DATE OF BIRTH 1-23-11		6 AGE (In years last birthday) 58 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital		12a USUAL OCCUPAT ON (K nd of work done during most of working life, even if retired) Manager & Owner		12b KIND OF BUSINESS OR INDUSTRY Happy Time To	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d INSIDE CITY LIM T5? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	
13e STREET AND NUMBER 3600 Gleneagles Drive		14 FATHER'S NAME First Middle Last Chester V. Lewis		15. MOTHER'S MAIDEN NAME First Middle Last Georgia Anthony			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b SOCIAL SECURITY NO (If yes give war or dates of service) 579 48 3729		17. INFORMANT Address Admission Recd., Montgomery Gen. Hospital, Olney			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> 16d1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 wks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 4/2/69		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED Ca of lung.		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 3/15, 1969, to 4/12, 1969, that (I) (we) last saw the deceased alive on 4/12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Richard A. Yates, MD				22c. DATE SIGNED 4/12/69		22d. ADDRESS OLNEY, Md.	
22e. PHYSICIAN'S NAME (Type) Richard A. Yates, MD		22f. ADDRESS OLNEY, Md.		22g. DEGREE DEGREE		22h. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 4/16/69		23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION (City or Town) (County) (State) Lynn, Massachusetts	
24. FUNERAL DIRECTOR Joseph Gawler's Son, 5130 Wisconsin Av., NW Wash. D.C.				25a. REC'D BY REGISTRAR DATE APR 15 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05654										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										0564																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First Middle Last Mandym E Jurist										4 Month 1 Day 69 Year										1:20 P M																													
3 SEX F										4 RACE W										5. DATE OF BIRTH 9/3/30										6. AGE (In years lost birthday) 38 YRS										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN									
7a. BIRTHPLACE (State or foreign country) N.Y.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.																			
10. CITY OR TOWN OF DEATH Silver Spring										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Mon.										13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 13335 Foxhall Dr.									
14. FATHER'S NAME First Middle Last ABRAMAM OKEAN										15. MOTHER'S MARDEN NAME First Middle Last ANNA SEIGEL										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO										16b. SOCIAL SECURITY NO. UNKNOWN										17. INFORMANT ALVIN JURIST Address (same as 13A)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of heart with DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized metastasis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH April 67 6 months										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.										21f. LOCATION Street or R.F.D. No City or Town County State																													
22a. I certify that (I) (his hospital) attended the deceased from Aug 14, 1968, to April 1969, that (I) (we) last saw the deceased alive on April 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Walter E. Goold MD										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED 4/1/69																													
22d. PHYSICIAN'S NAME (Type) WALTER E. GOOLD MD										22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 4-2-1969										23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery										23d. LOCATION (City or Town) (County) (State) IT WORTHING, LI N.Y.																			
24. FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																			
CONDORCE RIVERO Home 4217 9th St. NW																				DATE APR 7 1969										J Charles Judge																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~attach~~ ^{insert} the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05655		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05650	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Michael</i>			First	Middle	Last	2a. DATE OF DEATH 4 Month 17 Day 69 Year	
3 SEX <i>M</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>12/3/90</i>		2b. HOUR <i>8:30 AM</i>	
7a. BIRTHPLACE (State or foreign country) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Wheaton</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Radolph Hills Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Inspector Western Union</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY OR TNS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>1639 Jefferson ST.</i>		14. FATHER'S NAME First <i>Harris</i> Middle <i>Karelson</i> Last <i>Rose</i>		15. MOTHER'S MAIDEN NAME First <i>Rose</i> Middle <i>(Unknown)</i> Last <i>(Unknown)</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>101054768</i>		17. INFORMANT <i>Paul Karelson (son)</i>		Address <i>1030 Crane Rd., N.E. Atlanta, Georgia</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERMEDIATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i>						<i>2 days</i>	
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <i>Intermittent heart disease</i>						<i>10 yrs</i>	
DUE TO, OR AS A CONSEQUENCE OF							
(c) <i>Recurrent Malignancy</i>						<i>5-6 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<i>Jaundice (W) food</i>							
19a. DATE OF OPERATION <i>April 17, 1969</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 1966</i> , to <i>Apr 17 1969</i> , that (I) (we) last saw the deceased alive on <i>11 Apr 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Paul Karelson MD</i>						22c. DATE SIGNED <i>17 Apr 69</i>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>April 20, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Garden</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Virginia</i>	
24. FUNERAL DIRECTOR <i>Donald M. Stein</i>		ADDRESS <i>232 Carroll St., N.W. Wash., D.C.</i>		25a. REC'D BY REGISTRAR <i>APR 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05656

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05651

1. DECEASED NAME (Type or print)		First JAMES	Middle A.	Last KELLY	2a. DATE OF DEATH Month Day Year April 21, 1969			2b. HOUR 4:00 M	
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH Sept. 8, 1884		6 AGE (In years last birthday) 84		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address) 6400 Landon Lane		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Guard - Govt - Retired		12b. KIND OF BUSINESS OR INDUSTRY Id			
13a USJAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INS OF CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 6400 Landon Lane	
14 FATHER'S NAME First Middle Last James August Kelly				15. MOTHER'S MAIDEN NAME First Middle Last Catherine McCallion					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes.		16b SOCIAL SECURITY NO. 216-46-0126		17 INFORMANT Daughter		Address Same as Item 13.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Cardiac Arrest									
DUE TO, OR AS A CONSEQUENCE OF									
4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease 8 years									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Generalized arteriosclerosis 10 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIT ON GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1962 , to Apr. 21, 1969 , that (I) (we) last saw the deceased alive on Mar. 17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Thomas F. O'Connor MD</i>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Apr. 21, 1969	
22d PHYSICIAN'S NAME (Type) THOMAS F. O'CONNOR, MD		22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-24-69		23c NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d LOCATION (City or Town) (County) (State) Arlington, Virginia			
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE <i>William Judge</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05657

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05652

1 DECEASED NAME (Type or Print) GEORGE R. KENNEBECK			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 29 Year 1969			2b HOUR M				
3 SEX Male	4 RACE White	5 DATE OF BIRTH 6/05/1892	6 AGE (In years next birthday) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 4 Day 29 Year 1969			2d HOUR 4:47 M	
7a BIRTHPLACE (State or foreign country) Iowa		7b CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery				
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dentist			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.			13b COUNTY Montgomery Sil. Sp.		13c CITY OR TOWN Silver Spring, Md.		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e STREET AND NUMBER 912 Hobbs Drive
14 FATHER'S NAME First George Middle Kennebeck Last Gleason			15 MOTHER'S MAIDEN NAME First Elizabeth Middle Gleason Last Gleason			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes give war or dates of service) Army 1954				16b SOCIAL SECURITY NO 220-32-6566
17 INFORMANT Mrs. Elizabeth Kennebeck Sil. Sp., Md.			18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4120 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion										
ACTUAL SIGNATURE Belden R. Reap, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED APRIL 29, 1969	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City or Town, County) 4414 Georgia Avenue, Silver Spring, Md.				
23a BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b DATE May 2, 1969		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d LOCATION (City or Town) (County) (State) Rock Arlington, Virginia		25a REC'D BY REGISTRAR MAV 5 1969		25b REGISTRAR'S SIGNATURE Charles Yordge
24 FUNERAL DIRECTOR R. J. Smith, 8414 Georgia Avenue, Silver Spring, Md.										

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Film 412 4/30/69 kk 05658 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05658													
1. DECEASED-NAME (Type or Print) First Middle Last Arthur A. Kilburg						2a. DATE KNOWN OF DEATH Month Day Year 4-23 1969			2b. HOUR 10:50 AM				
3. SEX male		4. RACE white		5. DATE OF BIRTH 5-7-05		6. AGE (in years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 4-23 1969		2d. HOUR 10:50 AM	
7a. BIRTHPLACE (State or foreign country) Iowa			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3629 Piney Br Rd S S Md				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Superintendent				12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8029 Piney Br Rd			
14. FATHER'S NAME First Middle Last Peter Kilburg				15. MOTHER'S MAIDEN NAME First Middle Last Mary Puetz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) NO				16b. SOCIAL SECURITY NO. 577-07-1370		17. INFORMANT Mrs. Mildred E. Kilburg				ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure due to DUE TO, OR AS A CONSEQUENCE OF (b) Barbiturate intoxication, apparently DUE TO, OR AS A CONSEQUENCE OF (c) self-inflicted												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4-23 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased ingested overdose of barbiturate							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State Silver Spring Montg. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED 4/23/1969					
23a. BURIAL, CREMATION (Specify)		23b. DATE 4-26-69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.					
24. FUNERAL DIRECTOR Francis J. Collins						ADDRESS 500 University Blvd. W., Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE APR 25 1969		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Checked with Medical Examiner

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05659										
CERTIFICATE OF DEATH										
05654										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Frederick J. King, Sr.						April 5 1969		7 26 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		June 19, 1907		61 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York		U.S.A.				Montgomery		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		Holy Cross		Retired Salesman		Auto Tires				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY L.M. 15? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Mont.		Rockville		YES <input type="checkbox"/> NO <input type="checkbox"/>		13014 Grenoble Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Albert King			Anne Dyer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No			074-10-8409		Nancy S. King		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>									1 day	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u>									years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Congestive Heart Failure</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21/65</u> to <u>4/5/69</u> , that (I) (we) lost saw the deceased alive on <u>4/2/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
<u>John J. Curry, MD</u>		<u>4/6/69</u>		<u>John J. Curry, MD</u>		<u>9801 Georgia Ave., Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Apr. 9, 1969		Gate of Heaven		Silver Spring, Md.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Francis J. Collins		APR 11 1969		<u>Francis J. Collins</u>						
500 University Blvd. W. Silver Spring, Md.										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b HOUR
JAMES		W		King				April 17 1969		2:20 AM
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male	Negro		3/22/14		55		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Montgomery				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Suburban Hospital		Retired						
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before date of death) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Montgomery		Gaithersburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		Rt 2		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		
William		King		BERTHA ?				Laytonsville, Md. Address Lillian Dorsey - (Daughter)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>										1 Week
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease</u>										yes
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>										yes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from 12 April 1969, to 19 April 1969, that (I) (we) last saw the deceased alive on 16 April 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)						
John S. Saita		17 April 69		JOHN S. SAITA						
22e. ADDRESS		22f. ADDRESS		809 Viers N. W. Rd						
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		4/22/69		Brook Grove Cemetery		Laytonsville, Md. Montg. Co.				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE				
George R. Brondan		24		J. Charles Judge		24 1969				

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05661

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05656

1. DECEASED-NAME (Type or Print) ARTHUR. A. KRUHM			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 4 Day 2 Year 1969			2b. HOUR M		
3. SEX M	4. RACE CAUC	5. DATE OF BIRTH Dec 16 1889	6. AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD 4-2 Year 1969 2d. HOUR 5:40 A		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 603 Rosemere Dr. Blacksmith				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 603 Rosemere Rd
14. FATHER'S NAME First John Henry Middle Krumm Last Krumm			15. MOTHER'S M maiden name First Mary Anne Middle Lager Last Lager					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		(If yes give war or date of service) WWI		16b. SOCIAL SECURITY NO		17. INFORMANT Harriet Krumm - Elmore ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma 188X DUE TO, OR AS A CONSEQUENCE OF (b) of Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Artery Heart Disease.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, and an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED APRIL 2, 1969		
23a. BURIAL, CREMATION OR MOV. (Specify) Burial		23b. DATE 4-4-69		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl		23d. LOCATION (City or Town) Baltimore Md		(County) (State)
24. FUNERAL DIRECTOR Donaldson Funeral Home Laurel				ADDRESS		25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05662

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05657

1. DECEASED-NAME (Type or print) SOL Stanley Middle Lazarus		2a. DATE OF DEATH 4 Month 30 Day 69 Year		2b. HOUR 4:30 PM
3. SEX M	4. RACE Caus.	5. DATE OF BIRTH 11-17-1898		6. AGE (in years last birthday) 70 YRS.
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. C. TIZEN OF WHAT COUNTRY? USA		8. COUNTY OF DEATH Montgomery Md.
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Univ. Nurs. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Builder
13a. USUAL RESIDENCE (Where deceased lived, if institution, give street address) STATE Md. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 9302 Piney Branch Rd.
14. FATHER'S NAME First Agon Middle Lazarus Last Lazarus		15. MOTHER'S MAIDEN NAME First Sarah Middle Samuelson Last Samuelson		Address 9302 Piney Branch Road, S.S., Md.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes give year or dates of service) WW I		16b. SOCIAL SECURITY NO. 217-125172		17. INFORMANT Mrs. Frances M. Lazarus
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG, LUL 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) BULLOUS EMPHYSEMA, CORONARY ARTERY DIS.				
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from July , 19 68 , to 4/30 , 19 69 , that (I) (we) last saw the deceased alive on 4/27 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death.				
22b. SIGNATURE David Goldenberg		22c. DATE SIGNED 4/30/69		22d. PHYSICIAN'S NAME (Type) DR. DAVID GOLDENBERG
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE May 1, 1969		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden
23d. LOCATION (City or Town) Falls Church, Virginia		23e. REC'D BY REGISTRAR MAY 5 1969		23f. REGISTRAR'S SIGNATURE [Signature]
24. FUNERAL DIRECTOR Donald M. Stein ADDRESS 232 Carroll Hebrew Memorial Funeral Home St., N.W. Wash., D.C.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

05663										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05658									
Item 5 Film 412 5/7/69 kk										CERTIFICATE OF DEATH																			
1. DECEASED-NAME (Type or print) <i>Mary L. Lee</i>					2a. DATE OF DEATH Month <i>4</i> Day <i>24</i> Year <i>1969</i>					2b. HOUR <i>5:00 PM</i>																			
3. SEX <i>Female</i>			4. RACE <i>Negroid</i>			5. DATE OF BIRTH <i>Feb. 22, 1887</i>			6. AGE (In years last birthday) <i>82</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery County Md.</i>																				
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>retired</i>			12b. KIND OF BUSINESS OR INDUSTRY																				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Rockville</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>203 Martins Lane</i>																	
14. FATHER'S NAME First <i>William H.</i> Middle <i>Lee</i>					15. MOTHER'S MAIDEN NAME First <i>Louise</i> Middle <i>Washington</i>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>no</i>			16b. SOCIAL SECURITY NO <i>577-05-2221</i>			17. INFORMANT Address <i>Adele L/ White 6425 14th St., N.W. D.C.</i>																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> <i>4125</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>W. Marcus M.D.</i>															22c. DATE SIGNED <i>4/25/69</i>														
22d. PHYSICIAN'S NAME (Type) <i>WILLIAM MARCUS, M.D.</i>															22e. ADDRESS <i>10620 Georgia Ave., Sil. Spr., Md.</i>														
23a. BURIAL, CREMATION, or other disposition <i>Burial</i>					23b. DATE <i>4/29/69</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Mem. Cem.</i>					23d. LOCATION (City or Town) (County) (State) <i>Suitland Maryland</i>														
24. FUNERAL DIRECTOR <i>Washington, D.C.</i>										45a. REC'D BY REGISTRAR <i>APR 30 1969</i>					25b. REGISTRAR'S SIGNATURE <i>William J. Jones</i>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
05664						CERTIFICATE OF DEATH						05659	
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Cecelia			McKeown			Leighton			4 Month 4 Day 69 Year 7:00 AM				
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (in years last birthday)				
Female			White			17 Sept 1887			81 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Penn			U. S.						Montgomery Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring, Md.			10045 Mansion St.			Housewife			own Home				
13a. USUAL RESIDENCE (Where deceased lived, if instnat on admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. RESIDE CITY LIM 157				
Md.			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				
10045 Mansion St.			First Middle Last			First Middle Last			Yes, no, or unknown (If yes give war or dates of service)				
			Andrew Brown			Mary Anne Lawler			No				
16b. SOCIAL SECURITY NO.			17 INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
none			McLaughlin Funeral Home Wilkes Barre, Penn			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident, thrombosis</u>			8 days				
						DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral arteriosclerosis</u>			5 yrs				
						DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>			15 yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
9a. DATE OF OPERATION			9b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
			HOUR A M Month Day Year P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			21g. CITY OR TOWN				
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No.			County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>68</u> , to <u>4 April</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3 April</u> , 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS				
Merton J. White			9 April 1969			Merton J. White			9911 Georgia Ave Silver Spring Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
			4/8/69			St. Mary's Cemetery			Hanover Township, Penn				
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REC'D BY REGISTRAR				
Warner C. Humphrey Inc. 8434 Ga. Ave Silver Spring, Md.			APR 11 1969			William J. Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05665

CERTIFICATE OF DEATH

05660

1. DECEASED NAME (Type or print) AGNES First V Middle LEON Last			2a. DATE OF DEATH Month APRIL Day 6 Year 1969			2b. HOUR 6:10 ^{PM}					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 1/13/1911		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH SILVER SPRING MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) FAIRLAND NURSING HOME 310 FAIRLAND RD		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY MONTG.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6014 ONONDAGA RD.			
14. FATHER'S NAME First ALEX Middle ST. JOHN Last MARY			15. MOTHER'S MAIDEN NAME First MARY Middle COULFIELD Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-68-6187		17. INFORMANT Address DR. HERBERT LEON, SAME AS # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Irreversible shock 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr. 24 hr Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pylonephritis - Hypertension - Arthritis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/4 , 19 68 , to 4/6 , 19 69 , that (I) (we) last saw the deceased alive on 4/5 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard P. Delaney				22c. DATE SIGNED 4/6/69				22d. PHYSICIAN'S NAME (Type) RICHARD P. DELANEY			
22e. ADDRESS 4323 HARVARD, SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/9/69		23c. NAME OF CEMETERY OR CREMATORY HOLY WOOD CEM.		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.					
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS 5130 WIS. AVE. N.W. WASHINGTON, D.C.				25a. REC'D BY REGISTRAR APR 11 1969				25b. REGISTRAR'S SIGNATURE J. Charles Jorgensen			



05666

CERTIFICATE OF DEATH

05661

1. DECEASED NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR		
(Baby Girl) LEPIANE					4 Month 21 Day 69 Year		1:30 PM		
3. SEX	4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE	WHITE		4/20/69		YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.	USA				MONTGOMERY		Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSP							
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Pr. Geo.'s		Grnbldt		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9168 Springhill Lane	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Lost		First Middle Lost							
DONALD CARL LEPIANE		GLORIA L.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
				Donald Carl Lepiane - father same #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) IMMATURITY									
769.0 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) PREMATURE RUPTURE OF MEMBRANES AT 4 MONTH									
DUE TO, OR AS A CONSEQUENCE OF									
(c) INCOMPETENT CERVICAL OS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.							
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21c. LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 4/20/1968, to 4/21/1968, that (I) (we) last saw the deceased alive on 4/21/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
HERBERT FRIEDEL, M.D.								4/23/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
				11014 New Hampshire, Sfl. Spr., Md.					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/25/69		Gate of Heaven		Silver Spring, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Md.				DATE APR 28 1969		J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05667		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05662			
1. DECEASED NAME (Type or print)				First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Mary				C. Lewis		April 17 1969		328	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		12/23/82		86 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Texas		U.S.A.				Montgomery		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Grosvenor Lane Nursing Home		Housewife		Town Home			
13a. USLA. RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				10915 OAKWOOD ST.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address	
Henry		Cumpston		Mary Cumpston		220 54 2387		Charles F. Lewis (son) Same as # 13	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cardiac Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		3 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Arteriosclerotic H. disease				5 yrs	
		(c)		Generalized arteriosclerosis				20 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med cor examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1969, to 4/17, 1969, that (I) (we) last saw the deceased alive on 4/16/69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Ronald W. Barr, M.D.				Ronald W. Barr, M.D.					
23a. BURIAL CREMATION (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCAT ON (City or Town) (County) (State)			
Burial		4/20/69		Rose Hill Cemetery		Bloomington Grove Navarro Texas			
24. FUNERAL DIRECTOR		4739 Baltimore Ave., Hyattsville		REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch Sons Funeral Home, Md.				APR 21 1969		Francis Gasch			

Apr 24 L/Ham
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clothes
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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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05668

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05668

1 DECEASED-NAME (Type or Print) <u>Margaret H. Line</u>		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month <u>4</u> Day <u>24</u> Year <u>1969</u>		2b HOUR <u>11 AM</u>
3 SEX <u>Fe</u>	4 RACE <u>Cauc</u>	5 DATE OF BIRTH <u>1-8-1904</u>	6 AGE (in years) <u>65</u> YRS	7 UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		7b CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Montgomery</u> Md
10 CITY OR TOWN OF DEATH <u>Silver Spring</u>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>13213 HOLDRIDGE RD.</u>		12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.) <u></u>
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>MD.</u>		13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Cherry Hill</u>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME First <u>RUDOLPH</u> Middle <u></u> Last <u>LUEDECKE</u>		15 MOTHER'S MAIDEN NAME First <u>ANNA</u> Middle <u>RICHTER</u> Last <u>Luedecke</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO. <u>141-01-3770</u>	17. INFORMANT <u>ERIC RAYMOND HAARS, SON, SAME AS #73</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound, left</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chest, apparently self-inflicted.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute depression</u>				APPROX MATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A M. <u>4-24</u> P.M. <u>1969</u>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Deceased shot self with .22 cal. pistol</u>	
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>	21f LOCATION Street or R.F.D. No. <u>13213 Holdridge Rd.</u> City or Town <u>S.S. Montg. Md.</u> County <u></u> State <u></u>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Sign in city, town, or county) <u>BELDEN R. REAP, M.D., 21201</u>		
23a BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b DATE <u>4-28-1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
24 FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SON, INC.</u>		23d LOCATION (City or Town) (County) (State) <u>Suitland, Prince Georges Co., Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1969</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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05669

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05664

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
May		B		Linthicum	Month Day Year Apr. 15 '69		8 ¹⁵ PM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 24 HRS		
Female	W		5-5-85		83 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery Co. Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Colonial Village H. 12325 New Hampshire St.		housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		12604 Pendennis Rd. S.S.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Barnibus William Baker		Ida W. James							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No				Mrs. Wm J. Drey, 12604 Pendennis Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Aec -								minutes	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last								Today	
(b) Gm Cerebral hemorrhage -									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Cerebral hemorrhage -								2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4/8/1969 to 4/15/1969, that (I) (we) last saw the deceased alive on 4/15/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Howard T. Morse M.D.		4/15/69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Howard T. Morse M.D.		7030 Carrollton Parkway Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 18, 1969		Fort Lincoln Cemetery		Colmar Manor Md.			
24. FUNERAL DIRECTOR		ADDRESS		25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John J. Staloff		254 Carroll St NW		APR 18 1969		John J. Staloff			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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Item 7 Film 411
4/22/69
05670
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05665

1 DECEASED-NAME (Type or Print)		First PHILIP		M. date (MMN)		Last LIPSCHUTZ		2a DATE KNOWN OF ESTI DEATH: MATED <input checked="" type="checkbox"/> April 14 1969		2b HOUR 2:00	
3 SEX Male	4 RACE White	5. DATE OF BIRTH Dec. 7, 1890		6. AGE (In years last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month April Day 14, Year 19 69	
7a BIRTHPLACE (State or foreign country) Russia		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery				2d. HOUR 3:00	
10. CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hsop.		12a. USUAL OCCUPATION (Kind of work done during most of work life even if retired) Retired Laundry Supplier		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived admission) STATE NY		13b. COUNTY Brooklyn		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2026 Ocean Ave.			
14. FATHER'S NAME First SHLOMO Middle LIPSCHUTZ Last LEAH		15 MOTHER'S MAIDEN NAME First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Helen Price 6008 10th Place Chillum Md.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Disease. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2 a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John B. Ball John G. Ball M.D. Belden R. Roop, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED April 14, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/16/69		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d. LOCATION (City or Town) Helen N.J.		(County)		(State)	
24. FUNERAL DIRECTOR Bernard Danganan & Sons - 3501 W. 4th St. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR DATE APR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05671

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05666

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Joseph ^{First} EDGAR ^{Middle} Litchfield ^{Last}			2a. DATE OF DEATH Month 4 Day 7 Year 69			2b. HOUR 2:30 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-17-84		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Building Inspector		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Laurel Md		13b. COUNTY Howard		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 950 Nichols Drive	
14. FATHER'S NAME First Joseph Middle - Last Litchfield			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Brown Last Litchfield						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Wash. Address San. & Hosp. Carroll Ave. Takoma PK, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA - thrombosis 162.1 DUE TO, OR AS A CONSEQUENCE OF Brain metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Bronchogenic carcinoma (b) Brain metastases DUE TO, OR AS A CONSEQUENCE OF Brain metastases (c) Bronchogenic carcinoma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) TUMOR HEAD OF PANCREAS (SCAN EX) ASHD; BPH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS MONTHS MONTHS	
19a. DATE OF OPERATION 3/25/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/23 , 19 69 , to 4/7 , 19 69 , that (I) (we) last saw the deceased alive on 4/7 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kenneth Crize				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/7/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		23b. DATE 4-10-69		23c. NAME OF CEMETERY OR CREMATORY Imperial Cem		23d. LOCATION (City or Town) (County) (State) Laurel Md			
24. FUNERAL DIRECTOR Canadecan Funeral Home				ADDRESS Laurel Md		25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the special director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05672 CERTIFICATE OF DEATH 05667									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR P
Fannie Elizabeth Loun						April 17 1969			5:55 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		March 9, 1911		58 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney			Montgomery General Hospital			Housewife			
13a. USUAL RESIDENCE (Where deceased lived admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Montgomery		Monrovia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD # 1
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Albert W. Crum			Evie May Burke						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) no			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
					Records Montgomery General Hospital, Olney, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) <u>Renal Failure</u>									12 hrs.
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Hypertension</u>									
DUE TO, OR AS A CONSEQUENCE OF.									
(c) <u>Congenital Partial Aortic Obstruction</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Renal Insufficiency</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4/12/69		Isolated Duodenal Ulcer		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BJT'G <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.O. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 4/11, 1969, to 4/17, 1969 that (I) (we) last saw the deceased alive on 4/17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Arthur F. Woodward				<input checked="" type="checkbox"/>				4/18/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Arthur F. Woodward, M.D.		115 N. Van Buren St., Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		4/20/69		Providence Meth.		Kempton, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Olin L. Molesworth,		DATE		APR 22 1969		Charles J. J. J.			
Damascus, Md.									

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05673

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05668

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR
Emma					Lynn	4-4 19 69			720 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Female	White	Dec. 8, 1876	92 YRS.			4 4 19 69			720 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Lima, Peru		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Takoma Park		8519 Garland Avenue		Housewife		Own Home			
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Montgomery		Takoma Park				8519 Garland Avenue	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Heinrich					Hildebrand	Barbara			Platzer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT			
no			Yes			1311 Pinecrest Court James Lynn (son) Silver Spring, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Acute Coronary Insufficiency Arteriosclerotic Heart Disease									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
Belden R. Reap		Belden R. Reap				APRIL 5, 1969			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Apr. 8, 1969		Inglewood Park Cemetery		Los Angeles, California			
24 FUNERAL DIRECTOR		C. Glen Carter		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Warner E. Pumphrey, Inc		8434 Ga. Avenue		Sat. Spg. Md.		APR 11 1969		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05674										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05663																																							
Information taken from birth certificate																				CERTIFICATE OF DEATH																																							
1. DECEASED-NAME (Type or print) <i>Odetta BIRLI</i>										First Middle Last <i>MAY BULKLEY</i>										20. DATE OF DEATH Month <i>April</i> Day <i>1</i> Year <i>1969</i>										2b. HOUR <i>4:30</i> M <i>PM</i>																													
3 SEX <i>Female</i>										4 RACE <i>white</i>										5. DATE OF BIRTH <i>April 1, 1969</i>										6. AGE (in years lost birthday) <i>---</i> YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS M.N. <i>15</i>									
7a. BIRTHPLACE (State or foreign country) <i>md.</i>										7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <i>Montgomery</i> Md.																													
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hosp</i>										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>										13b. COUNTY <i>mont</i>										13c. CITY OR TOWN <i>Wheaton</i>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER <i>10902 Backwill Dr.</i>																			
14. FATHER'S NAME First <i>NO</i> Middle <i>info</i> Last										15. MOTHER'S MAIDEN NAME First <i>Louise</i> Middle Last <i>MAY</i>																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO.										17 INFORMANT Address <i>mother</i>																																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Spontaneously (Premature)</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b) DUE TO, OR AS A CONSEQUENCE OF										(c) DUE TO, OR AS A CONSEQUENCE OF																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <i>Ronald Straus, MD</i>										DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <i>4/1/69</i>																																							
22d. PHYSICIAN'S NAME (Type) <i>DONALD STRAUS MD</i>										22e. ADDRESS <i>4301 Aspen Hill Rd. Rockville, Md.</i>																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b. DATE <i>4/3/69</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>										23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i>																													
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home Rockville, Md.</i>										25a. REC'D BY REGISTRAR <i>APR 7 1969</i>										25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05675		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05670			
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR	
First		Middle		Last		Month		Day	
NATHAN		NORMAN		MAYER		4 - 3 - 1969		3 15 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		Caucasian		Jan 5, 1893		76 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U. S. A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		Randolph Hills Nursing Home		Retired - Attorney		Law			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Rockville				6809 Tilden Lane	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
unknown		unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
yes		W W I		SON		J. E. Mayer 6809 Tilden La. Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure								1 week	
DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary heart disease								5 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 10/10, 1966, to 4/3, 1969, that (I) (we) last saw the deceased alive on 4/2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
S. W. Nealon Jr								4/3/69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
S. W. Nealon				915 19th St. N.W., Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		April 7, 1969		Arlington National		Arlington Arlington Va.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JOSEPH GAWLER'S SON, INC.		DATE APR 7 1969		g Charles Judge					
BT30 WISC. AVE., N. W. WASH., D. C. 20016									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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05676		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05676	
CERTIFICATE OF DEATH							
1. DECEASED NAME (Type or print) First Middle Last SUE ALICE McNULTY			2a. DATE OF DEATH Month Day Year 4-15-69			2b. HOUR 6:07 PM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 11-29-93		6 AGE (In years last birthday) 73 YRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SUBURBAN		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b COUNTY MONT.		13c CITY OR TOWN BETHESDA		13d INSIDE CITY L.M.T.S? YES NO <input type="checkbox"/>	
13e STREET AND NUMBER 5015 BATTERY LANE		14. FATHER'S NAME First Middle Last Charles A. Collins		15 MOTHER'S M.A.D.E.N. NAME First Middle Last Sarah C. Unglesbee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b SOCIAL SECURITY NO Unknown		17 INFORMANT Husband Same as item 13.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the Aorta Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the Aorta Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the Aorta Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the Aorta Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hr 10+ yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 1, 1968 to April 15, 1969 , that (I) (we) last saw the deceased alive on 4-15-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE W. Fleet Lockett		22c. PHYSICIAN'S NAME (Type) W. FLEET LUCKETT		22d ADDRESS 5000 Reno Road, N. W. Washington, D. C.		22e. DATE SIGNED 4-16-69	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 4-18-69		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.				25a REC'D BY REGISTRAR APR 21 1969		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05677

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05672

1. DECEASED-NAME (Type or print) Yahya (None) Melekoglu			2a. DATE OF DEATH Month April Day 30 Year 1969			2b. HOUR 11:25 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 1, 1901		6. AGE (In years last birthday) 68 YRS	
7a. BIRTHPLACE (State or foreign country) Europe-Russia		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San + Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter-U.S. Government		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY 13b		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2731 FORT BAKER DRIVE, SE		14. FATHER'S NAME First Ismail Middle Milke Last Manovic		15. MOTHER'S MAIDEN NAME First Fatima Middle Red Last linska			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 357-95-2359		17. INFORMANT PT's. CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis or septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Carcinoma of Stomach DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs - 1 week - 6 mos							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)							
19a. DATE OF OPERATION March 24, 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Stomach		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 16, 1969 to April 30, 1969 , that (I) (we) last saw the deceased alive on April 30, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lyle Williams M.D.		22c. DATE SIGNED May 1, 1969		22d. PHYSICIAN'S NAME (Type) Lyle Williams M.D.			
22e. ADDRESS 831 University Blvd E, Silver Spring, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/2/69		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park Cem.		23d. LOCATION (City or Town) (County) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR The S.H. Hines Co.		24a. ADDRESS 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1 (4)
30M REV. 1-69

05678		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05678	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Mella</i>		First ALICE		Middle A.	Last MELIA		2a. DATE OF DEATH Month 4 Day 17 Year 69
3. SEX F		4. RACE W		5. DATE OF BIRTH 10/12/89		6. AGE (In years last birthday) 79 YRS.	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Frontgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dale Cross Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Ind.</i>		13b. COUNTY Prince George		13c. CITY OR TOWN Morningside		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Alice Ann Limerick		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			
16b. SOCIAL SECURITY NO.		17. INFORMANT Curtis James Hicks				Address 2716 Kirkwood Pl Hyatt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Luetic Aortitis and C.N.S. Les</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/30</i> , 19 <i>69</i> , to <i>4/17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/17</i> , 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>B. A. Ostrow MD</i>		22c. DATE SIGNED <i>4/18/69</i>		22d. PHYSICIAN'S NAME (Type) DR. BERNARD OSTROW			
22e. ADDRESS 8107 Eastern Ave. S.S., Md. 20910							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
304 REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05679

05674

1. DECEASED-NAME (Type or print) First Middle Last HESTER NOREINE MERSEREAU			2a. DATE OF DEATH Month Day Year 4 23 69		2b. HOUR 8:45 P. M.
3. SEX F	4. RACE N		5. DATE OF BIRTH Oct. 14, 1919		6. AGE (In years last birthday) 49 YRS.
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2650 Norbeck Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NURSE	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE N.Y.		13b. COUNTY BRONX	13c. CITY OR TOWN N.Y.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1795 Clinton Ave.
14. FATHER'S NAME First Middle Last WALTER ANKARD			15. MOTHER'S MAIDEN NAME First Middle Last ALICE SNOWDEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO 112-26-7758	17. INFORMANT Robt. MR. MERSEREAU Address 1795 Clinton Ave. N.Y.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 1020 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Hepatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma Body Uterus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs. 1966					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Renal Metastatic Carcinoma, Rt.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-28, 1969 , to 4-23, 1969 , that (I) (we) last saw the deceased alive on 4-21, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Oliver P. Jackson, MD		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-24-69	
22d. PHYSICIAN'S NAME (Type) Robert L. Snowden		22e. ADDRESS 202 Marlboro Ln., Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/27/69		23c. NAME OF CEMETERY OR CREMATORY Sharp Street Cemetery	
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Md.		23d. LOCATION (City or Town) (County) (State) Sandy Spring Montg. Md.	
		25a. REC'D BY REGISTRAR APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles J. Jager	

Classified by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
05680					CERTIFICATE OF DEATH					05675				
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
Emile F. Meyer, Sr.									Month April Day 10 Year 1969			AM PM		
3 SEX			4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		IF JOWER 24 HRS.		
male			white		1-3-1885			87 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
La.			U.S.A.				Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda			Suburban			Retired - So. Pacific Railroad								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INS. OR CITY LIM. IS?		3e. STREET AND NUMBER					
Md			Montgomery		Bethesda		YES <input type="checkbox"/> NO <input type="checkbox"/>		6408 Earleham Drive					
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME					
			unknown						unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			6408 Earleham Dr. Bethesda, Maryland					
						Patricia Meyer								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Cerebrovascular accident										2 days				
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) arteriosclerosis														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Coronary arteriosclerosis														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. Month Day Year											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION								
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1966, to 4-10, 1969, that (I) (we) last saw the deceased alive on 4-9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED			22d. ADDRESS								
Jay R. Shapiro			4/10/1969			8218 Wisc. Ave., Bethesda, Md.								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. ADDRESS								
Jay R. Shapiro						8218 Wisc. Ave., Bethesda, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			4/12/1969			Gate of Heaven			Silver Spring, Md.					
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Tyson Wheeler Funeral Home			1331 Rockville Pike			APR 14 1969			Charles Judge					
			Rockville, Md											

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used on a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 412
5-14-69 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05681

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05676

1 DECEASED NAME (Type or Print) Eleanor R Miles			2a. DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> 4 Month 13 Day 69 Year 3:30 AM		
3 SEX Female	4 RACE White	5. DATE OF BIRTH 1-24-15	6 AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Route #3	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER Route #3
14 FATHER'S NAME First Herbert Middle L. Last Diamond			15 MOTHER'S MAIDEN NAME First Mary Middle Jones Last Jones		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO (If yes give war or dates of service) 577-01-0879		17. INFORMANT ADDRESS Howard Miles, Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia; severe DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Reap		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/13/1969	
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) Ernest C. Gartner	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4-16-69	23c NAME OF CEMETERY OR CREMATORY St Rose		23d LOCATION (City or town) (County) (State) Gaithersburg Mont. Md.	
24 FUNERAL DIRECTOR Ernest C. Gartner.		ADDRESS		25a. REC'D BY REGISTRAR APR 16 1969	25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05682

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05677

1. DECEASED-NAME (Type or print) James Sheldon Miller			2a. DATE OF DEATH Month April Day 23 Year 1969			2b. HOUR AM 9:37 M			
3 SEX Male		4. RACE White		5. DATE OF BIRTH 1 May 1953		6. AGE (In years last birthday) 15 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Pennsylvania		13b. COUNTY Loganton		13c. CITY OR TOWN Loganton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 84	
14. FATHER'S NAME First Middle Last Sheldon G. Miller			15. MOTHER'S MAIDEN NAME First Middle Last Doris L. Helb						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Bethesda, Maryland 20014 The Medical Records, The Clinical Center,					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Septicemia 2000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Caseating Splenitis, Question of Rupture DUE TO, OR AS A CONSEQUENCE OF (c) Acute Granulocytic Leukemia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours hours-days 5 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hemorrhagic Pneumonitis (7 days)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that XX (this hospital) attended the deceased from 7 November 1968 , to 23 April 1969 , that XX (we) last saw the deceased alive on 23 April 1969 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above XX (we) did (not) view the body after death.									
22b. SIGNATURE Charles Rosenbaum				22c. DATE SIGNED 23 April 1969		22d. PHYSICIAN'S NAME (Type) Charles Rosenbaum, M.D.			
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-69		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION (City or Town) (County) (State) Loganton, Clinton Co. Penna.			
24. FUNERAL DIRECTOR H Schuyler Romm		ADDRESS Loganton Pa.		25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>Items 7&8 Filled 4/24/69 kk</div> <div>05683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>05678</div>										
1. DECEASED-NAME (Type or Print)					2a. DATE KNOWN OF DEATH					
First Middle Last					ESTIMATED MONTH DAY YEAR HOUR					
RICHARD MINES					April 9, 1969 8:40 PM					
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	Negro		81 YRS			Month April Day 9, Year 19 69		8:40 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			Rear of 906 N. Stonestreet Ave.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Rockville		YES <input type="checkbox"/> NO <input type="checkbox"/>		906 N. Stonestreet Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR MIN.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
				8:10 PM 4-9-69		Conflagration				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
		Home		906 N. Stonestreet Ave.		Rockville		Montgomery, MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4/11/69		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
BURIAL		4-12-69		Lincoln Park		Rockville		Montg, MD		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE		
R.L. Snowden				Rockville, Md		APR 17 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
05684		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						05679	
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) JAMES			First Middle Last FRANKLIN MINTON			2a. DATE OF DEATH APRIL 30 1969		2b. HOUR 11:30 P.M.	
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH 18 MAR 23		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) TENN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) USN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before adm ssion) STATE VA.			13b. CITY OR TOWN VA. BEACH		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 464 LYNN SHORES DRIVE		
14. FATHER'S NAME First Middle Last AUBURN CLAUDE MINTON			15. MOTHER'S MAIDEN NAME First Middle Last MAUDE NMN McDOWELL			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 266-22-6774			17. INFORMANT Address VA. BEACH VA. MRS. VIXIAN MINTON 464 LYNN SHORES DR.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with widespread metastases 1317 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from Mar. 12 , 19 69 , to Apr. 30 , 19 69 , that (X) (we) last saw the deceased alive on Apr. 30 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.									
22b. SIGNATURES Donald K. Roeder		22c. DATE SIGNED 1 May 69		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (Type) Donald K. ROEDER, M.D.		22e. ADDRESS Naval Hospital, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-5-69		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) VIRGINIA BEACH, VA			
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin St., N.W. Washington, D. C.					25a. RECD BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE John L. ...		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05680											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Charles B. Mitchell						Month Day Year			11:30 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M.	W.	2/14/50	19 YRS	MONTHS DAYS		HOURS MIN		Month Day Year	11:30 P.M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH			
Penn		USA		WIDOWED		DIVORCED		Montgomery		MD	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg			108 Brooks Drive			Worker			Auto-Communications		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md			Montgomery			Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		108 Brooks Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Donald C. Mitchell			Mary C. Buennorth								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
			194-40-7259			Mathew (Mrs George) Lichner			Blacksburg		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest.										Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b) Self-inflicted -											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			1123 PM APR 16 1969			Shot self in left chest with Rifle					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		
			Running House			108 Brooks Ave			Gaithersburg Montgomery		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			John B. Ball			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER			April 7, 1969		
						DEPUTY MEDICAL EXAMINER					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal			4-7-69			Johnson Chapel Cemetery			Fayette Co. Pa.		
24. FUNERAL DIRECTOR			ROBERT A. PUMPHREY			25a. REC'D BY REG STRAR			25b. REGISTRAR'S SIGNATURE		
			Bethesda, Maryland			APR 15 1969			Charles Judge		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05686

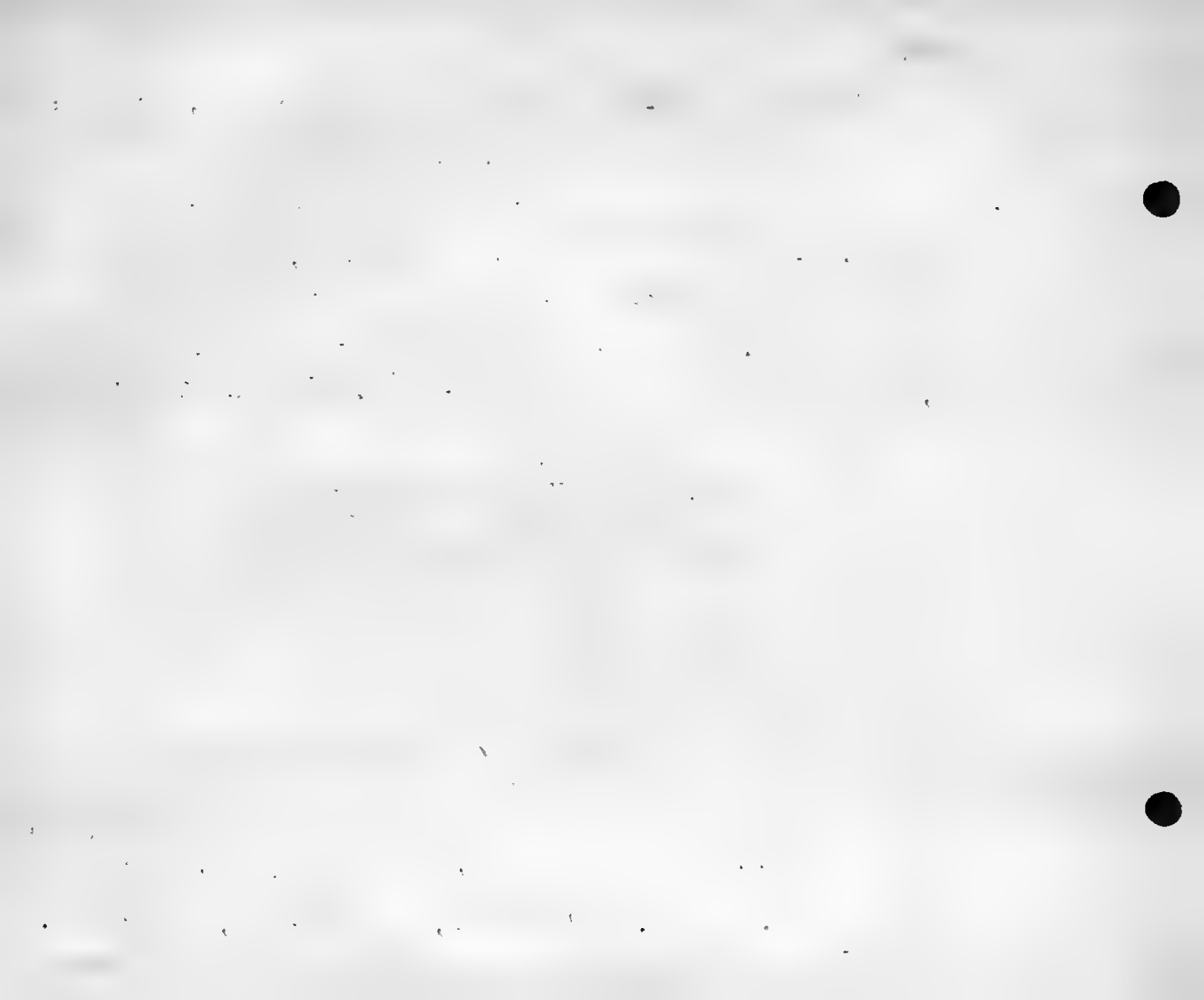
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05686

1. DECEASED NAME (Type or Print) Raymond C. Moore			2a. DATE KNOWN OF DEATH Month 4 - Day 22 Year 1969			2b. HOUR 5:45 P.M.			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 12-13-09	6 AGE (In years last birthday) 59 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN 0	2c. DATE PRONOUNCED DEAD Month 4 - Day 22 Year 1969	2d. HOUR 5:45 P.M.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1113 Spotswood Dr.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Auditor		12b. KIND OF BUSINESS OR INDUSTRY Pepco	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First James Middle E. Last Moore			15. MOTHER'S MAIDEN NAME First Annie Middle Fleming Last Fleming						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 577-05-0171			17. INFORMANT Mrs. Elaine L. Moore			
						ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation due to DUE TO, OR AS A CONSEQUENCE OF Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hanging DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Depression									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOJR A.M. 4-22-69 P.M.		21c. HOW INJURY OCCURRED (Enter not related to injury in Part 1 or Part 2 Item 18) Deceased, depressed, hanged				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION (Street or R.F.D. No. City or Town County State) (above) Silver Spring Montgo. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 4/22/1969			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (City, town, or county) Princeton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-25-69		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or town) (County) (State) Silver Spring, Md.			
24. FUNERAL DIRECTOR Francis J. Collins				ADDRESS 500 University Blvd. W., Silver Spring, Md.		25a. REC'D BY REGISTRAR APR 25 1969		25b. REGISTRAR'S SIGNATURE [Signature]	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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05687										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										05682																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First MIDDLE Last BERTHA BELLE MORRIS										April 15, 1969										3:00 A																																							
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH 6-22-80										6. AGE (In years last birthday) 88 YRS.										IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH MONTGOMERY Md.																													
10. CITY OR TOWN OF DEATH BETHESDA										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife.										12b. KIND OF BUSINESS OR INDUSTRY Own home																													
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND										13b. CITY OR TOWN Allegany (Cumberland)										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET AND NUMBER 54 GREENE ST.																													
14. FATHER'S NAME First MIDDLE Last Adam E. Boston										15. MOTHER'S MAIDEN NAME First MIDDLE Last Mary E. Hildebrandt										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.										16b. SOCIAL SECURITY NO. 136										17. INFORMANT 6012 MELVERN DR. Address ELIZABETH PARKER - DAUGHTER BETHESDA, MD																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Congestive Heart Failure																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																																											
(b) Coronary Artery Heart Disease																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
(c) Age - Pneumonia																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 1-2, 1969, to 4-14, 1969, that (I) (we) last saw the deceased alive on 4-14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE W.T. Joyce																				22c. DATE SIGNED April 15, 1969																																							
22d. PHYSICIAN'S NAME (Type) W.T. Joyce																				22e. ADDRESS 4977 Battery Lane, Bethesda																																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 4/17/69										23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery,										23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.																													
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock Pike Rockville, Maryland																				25a. REC'D BY REGISTRAR DATE APR 21 1969										25b. REGISTRAR'S SIGNATURE Charles Judge																													



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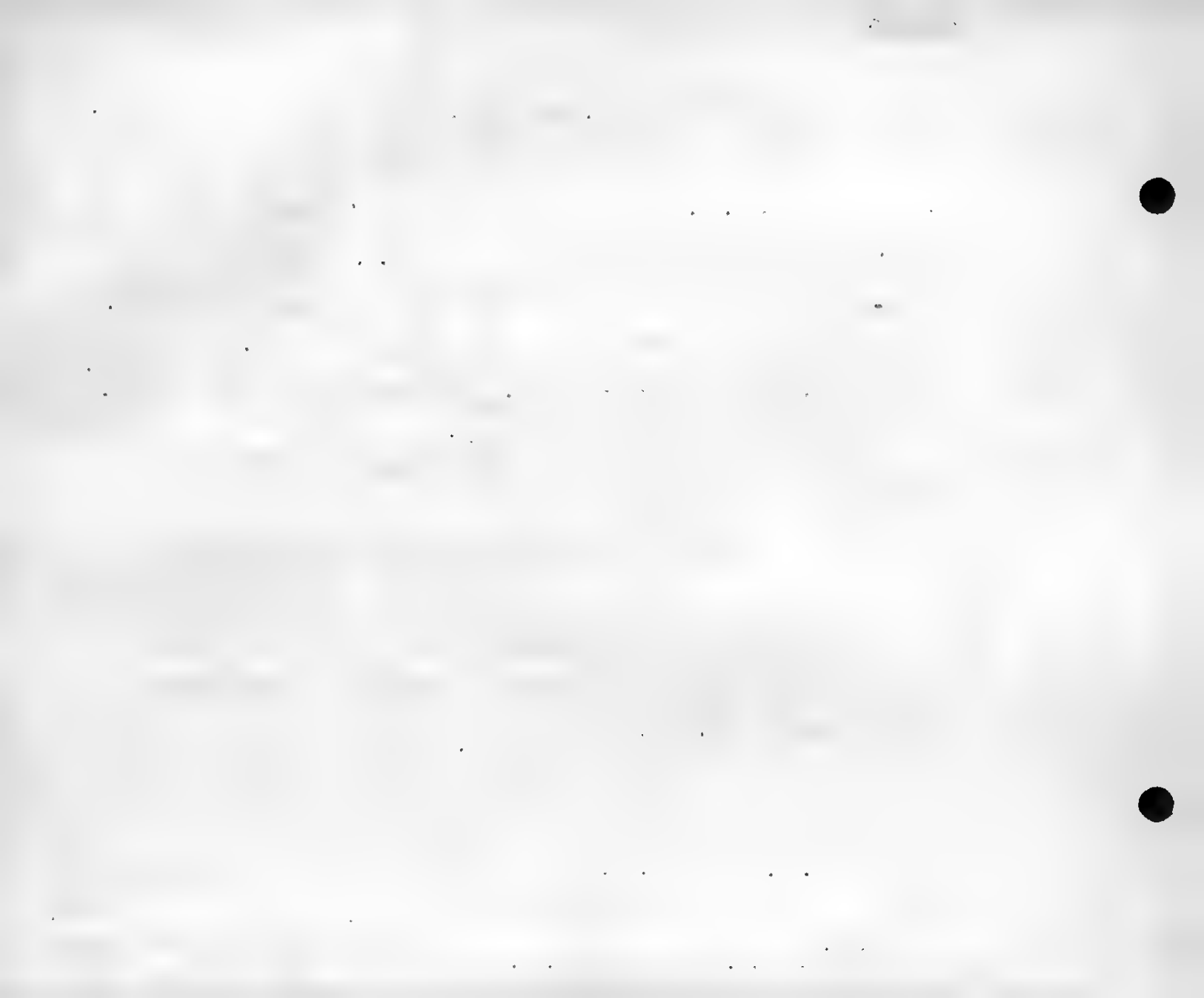
1

05688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05683

1. DECEASED-NAME (Type or print) First Middle Last HARRY LEO MORRIS, JR.			2a. DATE OF DEATH Month Day Year APRIL 7 1969		2b. HOUR 11:47
3 SEX MALE	4. RACE CAUC	5. DATE OF BIRTH 24 JANUARY 1926		6 AGE (In years last birthday) 43 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 2 7
7a. BIRTHPLACE (State or foreign country) Illinois	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY Md		
10. CITY OR TOWN OF DEATH BETHESDA	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. ARMED FORCES		12b KIND OF BUSINESS OR INDUSTRY USMC	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY MONTGOMERY	13c CITY OR TOWN BETHESDA	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 5355 POOK HILL RD.	
14 FATHER'S NAME First Middle Last HARRY LEO MORRIS		15. MOTHER'S MAIDEN NAME First Middle Last LETHA E. PAYNE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES		16b SOCIAL SECURITY NO 571-22-8349		17 INFORMANT (WIFE) MRS. CAROLYN ANNE MORRIS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF Spinal cord transection with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Paraplegia DUE TO, OR AS A CONSEQUENCE OF Fragmentation wounds of back		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. Feb 28 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) Wound to back during rocket attack			
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.) Marine Corps Base	21f. LOCATION Street or R.F.D. No City or Town County State Viet Nam			
22a. I certify that he (this hospital) attended the deceased from 10 MARCH , 19 69 , to 7 APRIL , 19 69 , that he (we) last saw the deceased alive on 7 APRIL 1969 , 19 69 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>D. L. Colgan</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) D. L. COLGAN M. D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 4-14-69	23c NAME OF CEMETERY OR CREMATORY Fort Rosecrans National Cem.	23d LOCATION (City or Town) (County) (State) San Diego Calif.		
24. FUNERAL DIRECTOR W. W. Chambers Co. 1400 Chapin St., N.W. Washington, D. C.		25a REC'D BY REGISTRAR APR 15 1969		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
05689						CERTIFICATE OF DEATH						05684	
1. DECEASED-NAME (Type or print)			First WILLIAM		Middle JACK		Last MORRIS		2a. DATE OF DEATH Month 4 Day 2 Year 69			2b. HOUR 8:30AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9-13-00			6. AGE (in years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.							
10. CITY OR TOWN OF DEATH OLNEY			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MONTGOMERY GENERAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY MONTG. COUNTY				
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CLARKSBURG		13d. INSIDE CITY L.M.T? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER ROUTE #2				
14. FATHER'S NAME First Middle Last SEBERT - MORRIS			15. MOTHER'S MAIDEN NAME First Middle Last CLEMENTINE - KNIGHT										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 219-34-8844		17. INFORMANT Address MEDICAL RECORD DEPT.								
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of rectum</i>												<i>unknown</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>with generalized</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastases</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pulmonary infarct</i>													
19a. DATE OF OPERATION 3/24/69		19b. CONDIT.ON FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of rectum</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 3/23, 1969, to 4/2, 1969, that (I) (we) last saw the deceased alive on 4/2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Arthur F. Woodward</i>				DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/2/69					
22d. PHYSICIAN'S NAME (Type) ARTHUR F. WOODWARD, M. D.				22e. ADDRESS 115 NORTH VANBUREN ST., ROCKVILLE, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-5-69		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Church		23d. LOCATION (City or Town) (County) (State) Quinque Greene Va.							
24. FUNERAL DIRECTOR <i>Ernest C. Gartner</i>				ADDRESS Gartnersburg. Md.		25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



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05690

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05685

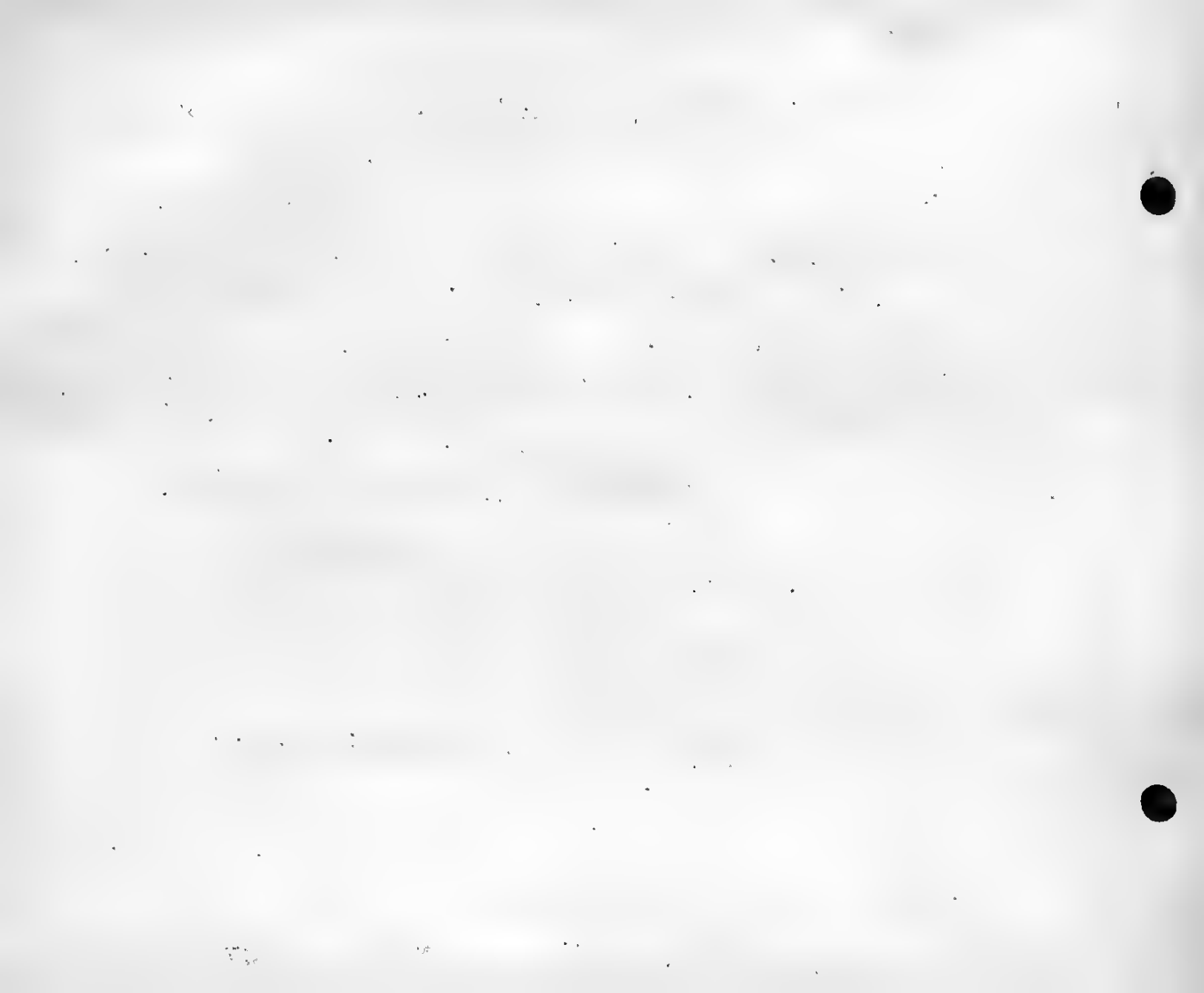
1. DECEASED NAME (Type or print) <u>May</u> <u>Helen</u> <u>Morrissey</u>			2a. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>69</u>			2b. HOUR <u>5³⁰</u> <u>A</u> <u>M</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>11-28-90</u>		6. AGE (In years last b rthday) <u>78</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>American</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Wash. San. & Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done) during most of working life, even if retired) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Rockville</u>		13e. STREET AND NUMBER <u>12104 Hitching Post Lane</u>	
14. FATHER'S NAME <u>John</u> <u>H.</u> <u>Kelly</u>		15. MOTHER'S MAIDEN NAME <u>Margaret</u> <u>McDonald</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u>		16b. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Daughter Mrs George Boyer</u> Same as Pt.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>4 day</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CVA</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <u>4</u> A.M. <u>13</u> Month <u>4</u> Day <u>14</u> Year <u>1969</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/3</u> , 19 <u>69</u> , to <u>4/14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R.H. Sandstrom MD</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/14/69</u>	
22d. PHYSICIAN'S NAME (Type) <u>R.H. Sandstrom MD</u>				22e. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4-14-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Syracuse, New York</u>	
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> <u>7557 Wisconsin Ave Bethesda, Md</u>				25a. REC'D BY REGISTRAR DATE <u>APR 21 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (9)
30M REV. 1768

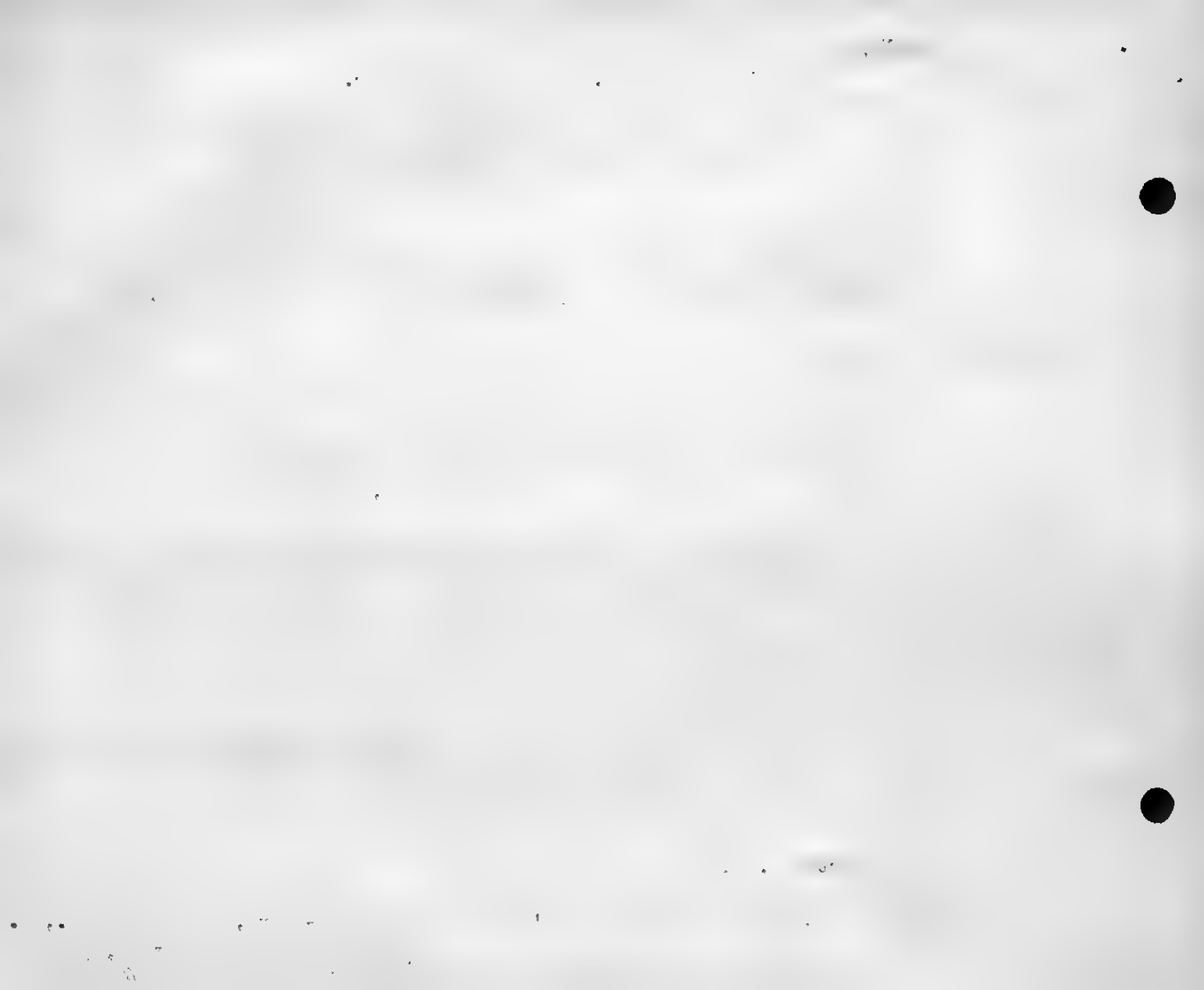
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
ANTHONY J. MOSCHETTO									Month 4 Day 9 Year 69			6 A M
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS
male		white		10-26-17				37 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
D.C.		2182				Montgomery Md.						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring				Holy Cross				RETIRED		newspaper		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
md				Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		709 VENICE DR.		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			First Middle Last
NUNZIO J. MOSCHETTO									LENETA Lupo			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
YES				WW II		519-10-6169		MRS. MOSCHETTO 13a & c & e above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mammary acute pulmonary edema</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>YRS.</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Partial hepatic liver</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>STRAC, 1964</u> to <u>APRIL 7, 1969</u> , that (I) (we) last saw the deceased alive on <u>APRIL 3, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type or print)		22e. ADDRESS				
<u>Albert H. Grollman M.D.</u>		<u>4/9/69</u>				<u>ALBERT H. GROLLMAN</u>		<u>1106 SPRING ST. - SILVER SPRING</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
<u>burial</u>		<u>12 APR. 1969</u>		<u>FORT LINCOLN CEMETERY</u>		<u>GLADENSBURG, MD.</u>						
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME, INC.</u> <u>7400 GEORGIA AVE. N.W. DC 20012</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
						<u>APR 11 1969</u>		<u>Charles Indel</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, lay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

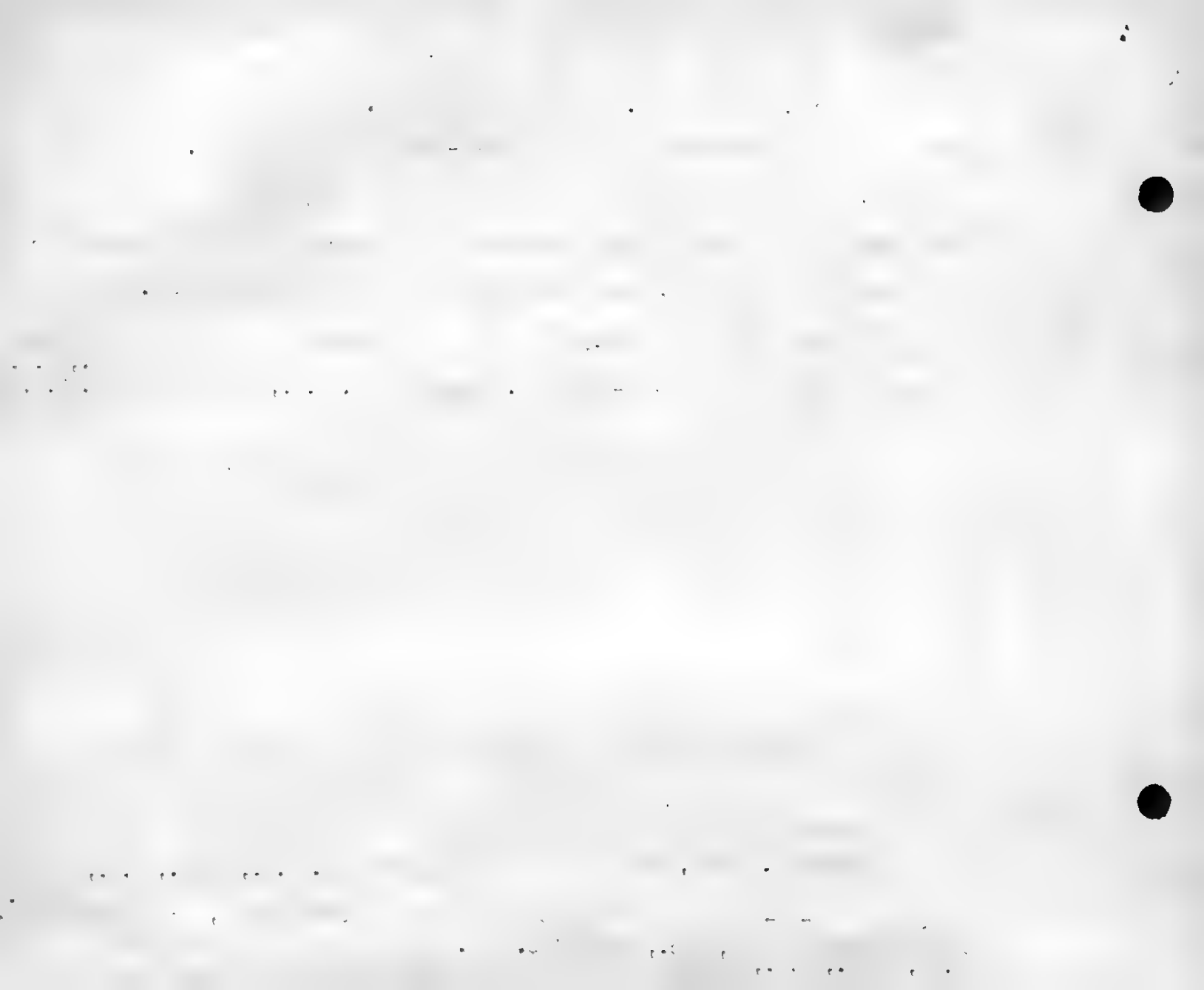
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
05692		CERTIFICATE OF DEATH						05687		
1. DECEASED NAME (Type or print) <i>William R. Moulden Jr.</i>		First <i>William</i>		Middle <i>R.</i>		Last <i>Moulden Jr.</i>		DATE OF DEATH Month <i>April</i> Day <i>16</i> Year <i>1969</i>		2b. HOUR <i>9 A</i> M
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>5/21/09</i>		6. AGE (In years last birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Executive</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>of Suburban Hosp.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		3d. INSIDE CITY, IN 15? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5430 PLANNED</i>		
14. FATHER'S NAME First <i>William</i> Middle <i>R.</i> Last <i>Moulden Jr.</i>		5. MOTHER'S MAIDEN NAME First <i>Mamie</i> Middle <i>Stewart</i> Last <i>Stewart</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>Yes</i>		16b. SOCIAL SECURITY NO <i>577-07-4137</i>		17. INFORMANT <i>Mary G. Moulden (Wife)</i>		Address <i>Same as above</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary arteriosclerosis, severe</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>1949</i> , to <i>16 April 1969</i> , that (I) (we) last saw the deceased alive on <i>15 April 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Merton L. White</i>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>16 April 1969</i>				
22d. PHYSICIAN'S NAME (Type) <i>Merton L. White</i>		22e. ADDRESS <i>9911 Georges Ave. Silver Spring, Md.</i>								
23a. BURIAL, CREMATION, REMOVA (Specify) <i>Burial</i>		23b. DATE <i>4-18-1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Saint Paul's Church Cemetery - Ivy, Albermarle Co., Va.</i>		23d. LOCATION (City or Town) (County) (State)				
24. FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SON, 1 ADDRESS</i>				25a. REC'D BY REG. STRAR DATE <i>APR 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05693												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
Item2 FilmG412 4/30/69 kk												CERTIFICATE OF DEATH																							
05688																																			
1 DECEASED-NAME (Type or print)				First				Middle				Last				2a DATE OF DEATH				2b HOUR															
Frank				J.				Murphy				Sr.				April 21				Month - 13 - Day 1969				2:20 P.M.											
3 SEX				4 RACE				5. DATE OF BIRTH				6. AGE (In years less months and days)				IF UNDER 1 YEAR				IF UNDER 24 HRS															
Male				Caucasian				8-5-1888				80 yrs.				MONTHS				DAYS				HOURS				MIN							
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9 COUNTY OF DEATH																							
New York				United States				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Montgomery																							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USAL OCCUPATION (Kind of work done during life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY																							
Chevy Chase				4515 Willard Avenue #207				Retired				Contractor																							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?				13e STREET AND NUMBER																			
Maryland				Montgomery				Chevy Chase				YES <input type="checkbox"/> NO <input type="checkbox"/>				4515 Willard Ave. #207 South																			
14. FATHER'S NAME				First				Middle				Last				15. MOTHER'S MAIDEN NAME				First				Middle				Last							
Patrick								Murphy								Nellie								Cooper											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)				(If yes give war or dates of service)				16b SOCIAL SECURITY NO				17 INFORMANT				Address																			
no								577-03-4108				Dr. Jerome Krick, M.D.,				2800 Quebec St. N.W.				Wash., D.C.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 1 DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>																								1 year											
402 X												DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) <u>Hypertension & hypertensive heart disease</u>																							
												DUE TO, OR AS A CONSEQUENCE OF																							
												(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																			
<u>Diabetes Mellitus Pernicious anemia</u>																																			
19a DATE OF OPERATION				19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?				20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																							
								YES <input type="checkbox"/> NO <input type="checkbox"/>																											
21a ACCIDENT WAS UNDERLYING				21b TIME OF INJURY				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																											
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. Month Day Year																															
(If either, notify medical examiner)				P.M. 19																															
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION				Street or R.F.D. No.				City or Town				County				State											
While <input type="checkbox"/> Not while <input type="checkbox"/>																																			
at work <input type="checkbox"/> at work <input type="checkbox"/>																																			
22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>4/13/69</u> , that (I) (we) last saw the deceased alive on <u>4/13/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b SIGNATURE				22c DATE SIGNED																															
<u>Jerome J. Krick, MD</u>				4-14-69																															
22d PHYSICIAN'S NAME (Type)				22e ADDRESS																															
Jerome J. Krick, MD				2800 Quebec St. N.W., Wash., D.C.,																															
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)				(County)				(State)															
Burial				4-16-1969				Fort Lincoln Cemetery				Colmar Manor, Prince Georges Co.								Md.															
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE																											
Joseph Gawler's Sons, Inc.,				APR 18 1969																															
N.W., Wash., D.C., 20016				DATE																															



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) S Elizabeth Musson			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year APR 13 1969			2b. HOUR 12:30 PM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH Dec. 23, 1877		6. AGE (In years and months) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year APR 13 1969	
7a. BIRTHPLACE (State or foreign country) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Wheaton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wheaton Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			
12b. KIND OF BUSINESS OR INDUSTRY Own home				13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. CITY OR TOWN Wheaton		13c. STREET AND NUMBER 13121 Holdridge Road	
14. FATHER'S NAME (unknown)				15. MOTHER'S MAIDEN NAME Mary Musson				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes give year or dates of service)			
16b. SOCIAL SECURITY NO 216-46-6181				17. INFORMANT Edward Hall Musson, Jr.,				ADDRESS Wheaton, Maryland 13121 Holdridge Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Fracture of Left Humerus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4 7 1969				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) Fell at home causing fracture of Left Humerus			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John B. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED April 13, 1969			
EXAMINER'S NAME (Type) John B. Ball				ADDRESS (Street, city, town, or county) St. Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE April 16, 1969				23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery			
23d. ADDRESS Warner E. Pumphrey, Inc. Silver Spring, Md.				24. REC'D BY REGISTRAR APR 18 1969				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05695

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05690

1. DECEASED NAME (Type or print) John Milton Nagel			2a. DATE OF DEATH Month 4 Day 29 Year 1969		2b. HOUR 8:25 AM
3 SEX male	4 RACE white	5. DATE OF BIRTH 6-28-09		6 AGE (In years last birthday) 59 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pa	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Printer	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md		13b. COUNTY Prince Georges		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Carl Middle Nagel Last Gray		15 MOTHER'S MAIDEN NAME First Pearl Middle Gray Last Gray		12b. KIND OF BUSINESS OR INDUSTRY G.P.O.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO -		17. INFORMANT Hospital chart	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 189.0 shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) left myocardium DUE TO, OR AS A CONSEQUENCE OF (c) lacunoma, left kidney					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 hours 2.0 hours unknown
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 4-28-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED lacunoma, left kidney		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DIRECT CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-5 , 19 69 , to 4-29 , 19 69 , that (I) (we) lost saw the deceased alive on 4-28 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Seruch T. Kimble, M.D.		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-29-69	
22d. PHYSICIAN'S NAME (Type) Seruch T. Kimble, M.D.		22e. ADDRESS 9801 Georgia Avenue, Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE May 2, 1969		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	
24. FUNERAL DIRECTOR W.W. Chambers Co		23d. LOCATION (City or Town) County State Suitland Maryland		23e. REC'D BY REGISTRAR 2 1969	
24. FUNERAL DIRECTOR W.W. Chambers Co		23d. LOCATION (City or Town) County State Suitland Maryland		23e. REC'D BY REGISTRAR 2 1969	
24. FUNERAL DIRECTOR W.W. Chambers Co		23d. LOCATION (City or Town) County State Suitland Maryland		23e. REC'D BY REGISTRAR 2 1969	

VR 4-69
45M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05696

CERTIFICATE OF DEATH

05691

1 DECEASED-NAME (Type or print) <u>Robert T. Newman</u>			2a DATE OF DEATH Month <u>11</u> - Day <u>2</u> - Year <u>1969</u>			2b HOUR <u>2</u> P M					
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>5/30/11</u>		6 AGE (In years last birthday) <u>57</u> YRS		IF UNDER 1 YEAR MONTHS <u>10</u> DAYS <u>02</u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a BIRTHPLACE (State or foreign country) <u>VA.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>MONTGOMERY</u> Md.					
1d CITY OR TOWN OF DEATH <u>Silver Spring</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hosp.</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Truck Driver</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>			13b. COUNTY <u>MONTGOMERY S.S.</u>			13d UNUS. OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <u>11507 Goodloe Rd.</u>		
14 FATHER'S NAME First <u>Thomas</u> Middle <u>Newman</u> Last <u></u>			5. MOTHER'S MAIDEN NAME First <u>Rosa</u> Middle <u>Humphrey</u> Last <u></u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give year or dates of service) <u>WWII</u>			16b SOCIAL SECURITY NO <u>705 01 6153</u>			17. INFORMANT Address <u>Maxine L. Newman-wife-same item # 13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4d</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Multiple old myocardial infarction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-24</u> , 19 <u>69</u> , to <u>4-2</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-2</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Abraham W. Danis</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-2-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANIS</u>						22e. ADDRESS <u>1106 SPRING ST SS MD</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>					
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1951 Rock Pike</u> <u>Rockville, Mary</u>		25a. REC'D BY REGISTRAR <u>APR 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

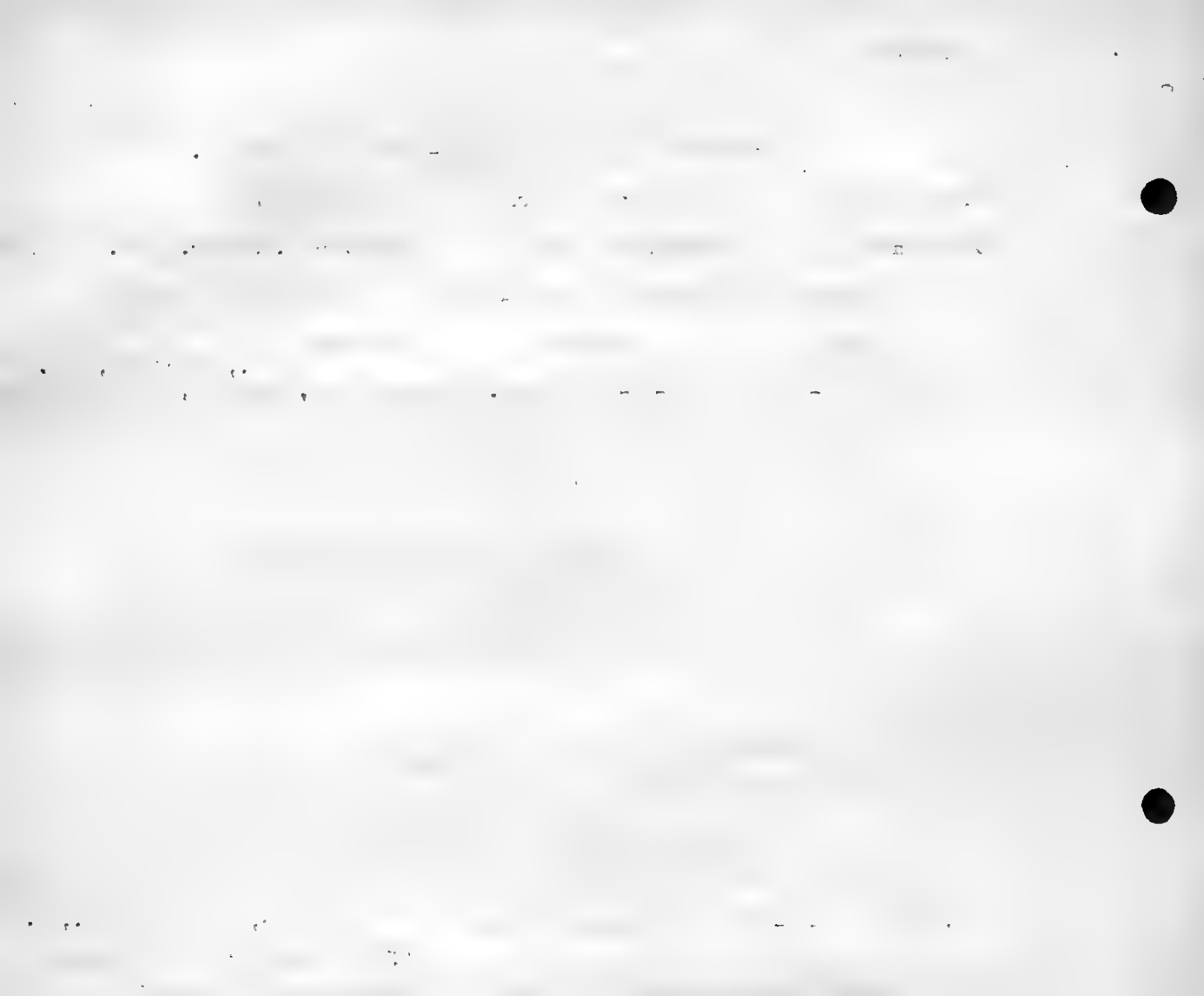
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05697					05692				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last					Month Day Year			P M	
Dorothy Orrienne Newton					April 21 1969			11:30 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		15 January 1909		60 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Massachusetts		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Connecticut			Hamden		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		# 11 Ridgewood Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Edwin Raymond Brackett			Evelyn Mandell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
No			not available		The Medical Records Address 20014 The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Intracerebral & Subarachnoid hemorrhage</u>									48 hours
4124 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Idiopathic Thrombocytopenic Purpura</u>									6 years
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Right-sided Cardiovascular Accident</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>15 April</u> , 19 <u>69</u> , to <u>21 April</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>21 April</u> , 19 <u>69</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED
<u>Arthur H. Weintraub</u>					M.D.				22 April 1969
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Arthur H. Weintraub M.D.					The Clinical Center, National Institutes of Health, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		4-29-69		Woodland Cemetery		Coventry		R. 1	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey					DATE		APR 28 1969		
7557-Wisconsin Ave., Bethesda, Md.							<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 05698 CERTIFICATE OF DEATH 05693 </div>											
1. DECEASED NAME (Type or print) JAMES T NICHOLSON						2a. DATE OF DEATH Month APRIL Day 15 Year 1969			2b. HOUR 11:55 PM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 10-31-1893		6. AGE (In years last birthday) 75 yrs.		7. UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give home address) 4906 Essex Avenue				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Executive Vice Pres.			12b. KIND OF BUSINESS OR INDUSTRY Amer. Red Cross		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4906 Essex Avenue			
14. FATHER'S NAME First Joseph Middle Nicholson Last Nicholson				15. MOTHER'S MAIDEN NAME First Elizabeth Middle Ayers Last Ayers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes WW - I				16b. SOCIAL SECURITY NO. 579-44-5484		17. INFORMANT Rd. add Dearfield, Ill. Mrs. Elizabeth Fish, Daughter, 1446 Windcrest					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURE ABDOMINAL ANEURYSM 441.2 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema Chronic Bronchitis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb 4 , 19 51 , to April 15 , 19 69 , that (I) (we) lost saw the deceased alive on April 15 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Theodore J. Adernethy M.D.						22c. DATE SIGNED 4-16-69					
22d. PHYSICIAN'S NAME (Type) Theodore J. Adernethy						22e. ADDRESS 916-19th St. N.W. Washington DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-18-1969		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery Co., Md.					
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SON, INC.		5130 WISC. AVE., N. W. WASH., D. C. 20015				25a. REC'D BY REGISTRAR APR 21 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05699

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05694

1. DECEASED-NAME (Type or print) Katherine C. NICTER			2a. DATE OF DEATH Month April Day 17 Year 1969			2b. HOUR 5:45 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-31-95		6. AGE (In years last birthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Co. Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Cafeteria Mgr.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE md.		13b. COUNTY Montgomery		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 611 Rosemeade St.		14. FATHER'S NAME First H. Robert Middle Steed Last		15. MOTHER'S MAIDEN NAME First Cora Middle (unknown) Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT (Son)		Address Great Falls		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO, OR AS A CONSEQUENCE OF (b) Adhesions peritoneal cavity DUE TO, OR AS A CONSEQUENCE OF (c) Unknown Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Malignant Lymphoma, paracortic area							
19a. DATE OF OPERATION 4-16-69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Nov , 1968, to April 18 , 1969, that (I) (we) last saw the deceased alive on April 18 , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Aaron H. Traumm		22c. DATE SIGNED April 19 1969		22d. PHYSICIAN'S NAME (Type) Aaron H. Traumm		22e. ADDRESS 8237 Georgia Ave - Silver Spring Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 22, 1969		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.		23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		24a. REC'D BY REGISTRAR APR 24 1969		24b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05700

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05695

1 DECEASED-NAME (Type or print) <i>Charles William Noske</i>			2a. DATE OF DEATH Month <i>4</i> Day <i>4</i> Year <i>1969</i>			2b. HOUR <i>10 30</i> A.M.	
3 SEX <i>MALE</i>		4. RACE <i>CAUC.</i>		5. DATE OF BIRTH <i>6-22-73</i>		6. AGE (In years last birthday) <i>95</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>AMERICAN</i>		8. MARRIED <input type="checkbox"/> NEVER MARR. ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Mo	
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington SAN & Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Ins. Salesman</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Beltsville</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER <i>13101 Long Drive</i>		14. FATHER'S NAME First <i>Charles</i> Middle <i>Noske</i> Last <i>Noske</i>		15. MOTHER'S MAIDEN NAME First <i>Rose</i> Middle <i>?</i> Last <i>?</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577-05-7535</i>		17. INFORMANT <i>Chart</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable Asystole</i> <i>4</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized aging</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>several years</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Acute cystitis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>401</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>April 3, 1969</i> to <i>April 4, 1969</i> , that (I) (we) lost saw the deceased alive on <i>April 4, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edw. Magi, M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>April 5, 1969</i>			
22d. PHYSICIAN'S NAME (Type) <i>EDW MAGI</i>				22e. ADDRESS <i>831 Univ. Blvd. E. Silver Spring, Md.</i>			
23a. BURIAL, CREMATION <i>Burial</i>		23b. DATE <i>4/8/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor, Md.</i>	
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>				25a. REC'D BY REGISTRAR <i>APR 10 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05701

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <u>Matthew Harry</u> <u>Novak</u>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>4</u> Day <u>4</u> Year <u>69</u>			2b. HOUR <u>8:15</u> AM		
3. SEX <u>Male</u>	4. RACE <u>Cauc</u>	5. DATE OF BIRTH <u>Feb. 8, 1903</u>	6. AGE (in years) <u>66</u> YRS	if UNDER 1 YEAR MONTHS <u>4</u> DAYS <u>4</u>	if UNDER 24 HRS HOURS <u>4</u> MIN <u>4</u>	2c. DATE PRONOUNCED DEAD Month <u>4</u> Day <u>4</u> Year <u>69</u>		
7a. BIRTHPLACE (State or foreign country) <u>Penna.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.		
10. CITY OR TOWN OF DEATH <u>Wheaton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Univ. Tsg. Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Bookkeeper</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>D.C.</u>		13b. COUNTY <u>—</u>		13c. CITY OR TOWN <u>WASH.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>336 Md. Ave., N.E.</u>
14. FATHER'S NAME First <u>UNKNOWN</u> Middle <u>—</u> Last <u>—</u>				15. MOTHER'S MAIDEN NAME First <u>UNKNOWN</u> Middle <u>—</u> Last <u>—</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>579 093532</u>		17. INFORMANT <u>BERNARD J. NOVAR</u> ADDRESS <u>724 N. 23rd ST. PHILLIDELPHIA, PA.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>of Lung</u> (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <u>19</u> HOURS A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>APRIL 4, 1969</u>		
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town, County) <u>Wheaton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>	23b. DATE <u>4-11-1969</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City or Town) (County) (State) <u>Montgomery</u> <u>Phila</u> <u>School</u> <u>3900 Reservoir Rd. N.W. Wash. D.C.</u>				
24. FUNERAL DIRECTOR <u>Wm. Charles C. Silver Spring Md.</u>		ADDRESS <u>—</u>		25a. REC'D BY REG. STRAR <u>APR 15 1969</u>		25b. REGISTRAR'S SIGNATURE <u>William C. Silver</u>		

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05702		CERTIFICATE OF DEATH						05697	
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
KERRY JOANN NYGREN						APR 11 th 8 Day 1969		3:38 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 24 HRS	
FEMALE		CAUCASIAN		MAY 23, 1955		lost 5 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
NEBRASKA		USA				MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL		STUDENT					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER			
VIRGINIA		FAIRFAX		VIENNA YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1410 CARRINGTON LANE			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
HARLEY D. NYGREN			NORMA M. GROBEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1410 CARRINGTON LANE, VIENNA, VIRGINIA 22180			
		N/A		FATHER HARLEY D. NYGREN					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 190x ACUTE LARYNGOTRACHEOBRONCHITIS with BILATERAL BRONCHOPNEUMONIA								40 Hours	
DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (this hospital) attended the deceased from April 6, 1969, to April 8, 1969, that (I) (we) lost the deceased alive on April 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
								8 April 1969	
22d. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, CDR MC USN				22e. ADDRESS					
				NAVAL HOSPITAL, BETHESDA, MARYLAND					
23a. BURIAL, CREMATION, OR OTHER (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 11, 1969		National Memorial Park Falls Church, Fairfax, Va					
24. FUNERAL DIRECTOR		25. DIED BY REGISTER		25b. COUNTY REGISTRAR'S SIGNATURE					
PEARSON'S FUNERAL HOME Falls Church, Virginia		APR 11 1969		J. M. Jackson					

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
05703													
CERTIFICATE OF DEATH													
05688													
1. DECEASED-NAME (Type or print) <i>Lucy</i>			First <i>A.</i> Middle <i>Nylen</i> Last			2a. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1969</i>			2b. HOUR <i>4:10</i> M				
3 SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1/16/85</i>		6 AGE (In years last birthday) <i>84</i> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			Md.		
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Ret. Sales Lady</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before 1 year on) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Hyattsville</i>		13d. INSIDE CITY, UNITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2333 New Hampshire Ave</i>			
14 FATHER'S NAME <i>Bachley</i>			First <i>Harner</i> Middle <i>(Linn)</i> Last			15 MOTHER'S MAIDEN NAME <i>(Linn)</i>			First <i>Harner</i> Middle <i>(Linn)</i> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>226-16-0971</i>			17 INFORMANT <i>Son</i>			Address <i>Same as above</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CIRCULATORY COLLAPSE</i>										<i>1/2 hr</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>MYOCARDIAL INFARCTION, ACUTE</i>										<i>6 DAYS</i>			
(c) <i>ARTERIOSCLEROTIC HEART DISEASE</i>										<i>10+ YRS</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>CONGESTIVE HEART DISEASE - DIVERTICULOSIS</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>MAY</i> , 19 <i>58</i> , to <i>PRESENT</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>16 APRIL</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Charles J. Savarese Jr. M.D.</i>										22c. DATE SIGNED <i>4/17/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>CHARLES J. SAVARESE, JR. M.D.</i>										22e. ADDRESS <i>11,125 ROCKVILLE PIKE, ROCKVILLE, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>April 19, 1969</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, Maryland</i>				
24 FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc. Silver Spring, Maryland</i>										25a. BY REGISTRATION <i>APR 21 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	

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1 MEXICAN NOTIFIED

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05704		CERTIFICATE OF DEATH				05693			
1. DECEASED NAME (Type or print) First Middle Last Nell G. O'Connell			2a. DATE OF DEATH Month Day Year April 10 1969			2b. HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH March 29, 1896		6 AGE (In years last birthday) 73 YRS.		F UNDER 1 YEAR MONTHS DAYS F UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Lincoln, Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1001 Spring St., S.S., Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Can home			
13a. U.S.A. RESIDENCE (Where deceased lived, if institut on admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1001 Spring Street	
14. FATHER'S NAME First Middle Last George Dowdle			15. MOTHER'S MAIDEN NAME First Middle Last (UNKNOWN) McCarthy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO ?		17. INFORMANT Charles G. O'Connell, 8503 Mayfair Place,		Address: St Sil. Spr., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive endocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat. fy medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>April</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>3/15</u> 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.									
22b. SIGNATURE <u>James C. Mandes</u> M.D. DEGREE		22c. DATE SIGNED 4/10/69		22d. PHYSICIAN'S NAME (Type) James C. Mandes MD		22e. ADDRESS 1631 16th St., NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 14, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR C. Glen Carter 18434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.				25a. REC'D BY REG STRAR APR 17 1969		25b. REGISTRAR'S SIGNATURE Charles Jones			

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05705

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05100

1. DECEASED-NAME (Type or print) GEORGE W. O'KEEFE			2a. DATE OF DEATH Month April Day 20 Year 1969			2b. HOUR 2:30 A M	
3 SEX male		4. RACE white		5. DATE OF BIRTH 6/7/01		6 AGE (In years last birthday) 67 YRS	
7a. BIRTHPLACE (State or foreign country) Conn		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired) RET. - ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY LAW	
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY OR TOWN Cherry Chase		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1604 HARRISON ST.	
14 FATHER'S NAME First Middle Last PATRICK S. O'KEEFE			15 MOTHER'S MAIDEN NAME First Middle Last ROSE				
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not or unknown NO		17b. SOCIAL SECURITY NO 578-10-4572		17 INFORMANT 12511 Twinbrook Pk. Address Licksville Richard Bass - Nephew			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Heart and Lung Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs 4 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of the Pancreas - Part of b. pyloric operation							
19a. DATE OF OPERATION 15 Sept		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Pancreas		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-4-1967 , to 4-20-1967 , that (I) (we) last saw the deceased alive on 4-17-1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William H. Killay M.D.				22c. DATE SIGNED 4-20-69			
22d. PHYSICIAN'S NAME (Type) WILLIAM H. KILLAY				22e. ADDRESS 8218 W.S. AVE. BETH., MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-23-69		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR JOS. GAWLER'S SONS, 5130 WASHINGTON AVE. WASHINGTON, D.C.				25a. RECD BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE	

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1

05706

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05701

1. DECEASED-NAME (Type or print) Nettie None Orendorff			2a. DATE OF DEATH Month 4 Day 18 Year 89			2b. HOUR 5:00 PM					
3. SEX Female		4. RACE Wht		5. DATE OF BIRTH 10-7-89		6. AGE (in years lost birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia			13b. COUNTY Fairfax		13c. CITY OR TOWN Falls Church		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7250 Edylwood Rd.		
14. FATHER'S NAME First Edward Middle Pennell Last Elsa			15. MOTHER'S MAIDEN NAME First Dorthea Middle Bonneau Last Bonneau								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 262-44-0693			17. INFORMANT Hosp. Record Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Surgical Stress									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs years 48 hours		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus & Adenocarcinoma of Endometrium with metastases											
19a. DATE OF OPERATION April 16, 1969			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RECTOCOLIC & ABD. INCISIONAL HERNIA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1969 , to April 18, 1969 , that (I) (we) last saw the deceased alive on April 18, 1969 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Naor W. Stoehr M.D.						DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4-18-69	
22d. PHYSICIAN'S NAME (Type) Naor W. Stoehr						22e. ADDRESS Takoma Park Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) 4/19/69			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City or Town) (County) (State) Switzland Maryland		
24. FUNERAL DIRECTOR Pearson's Funeral Home						ADDRESS Falls Church, Va		25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE William S. Jackson	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05707

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05702

CERTIFICATE OF DEATH

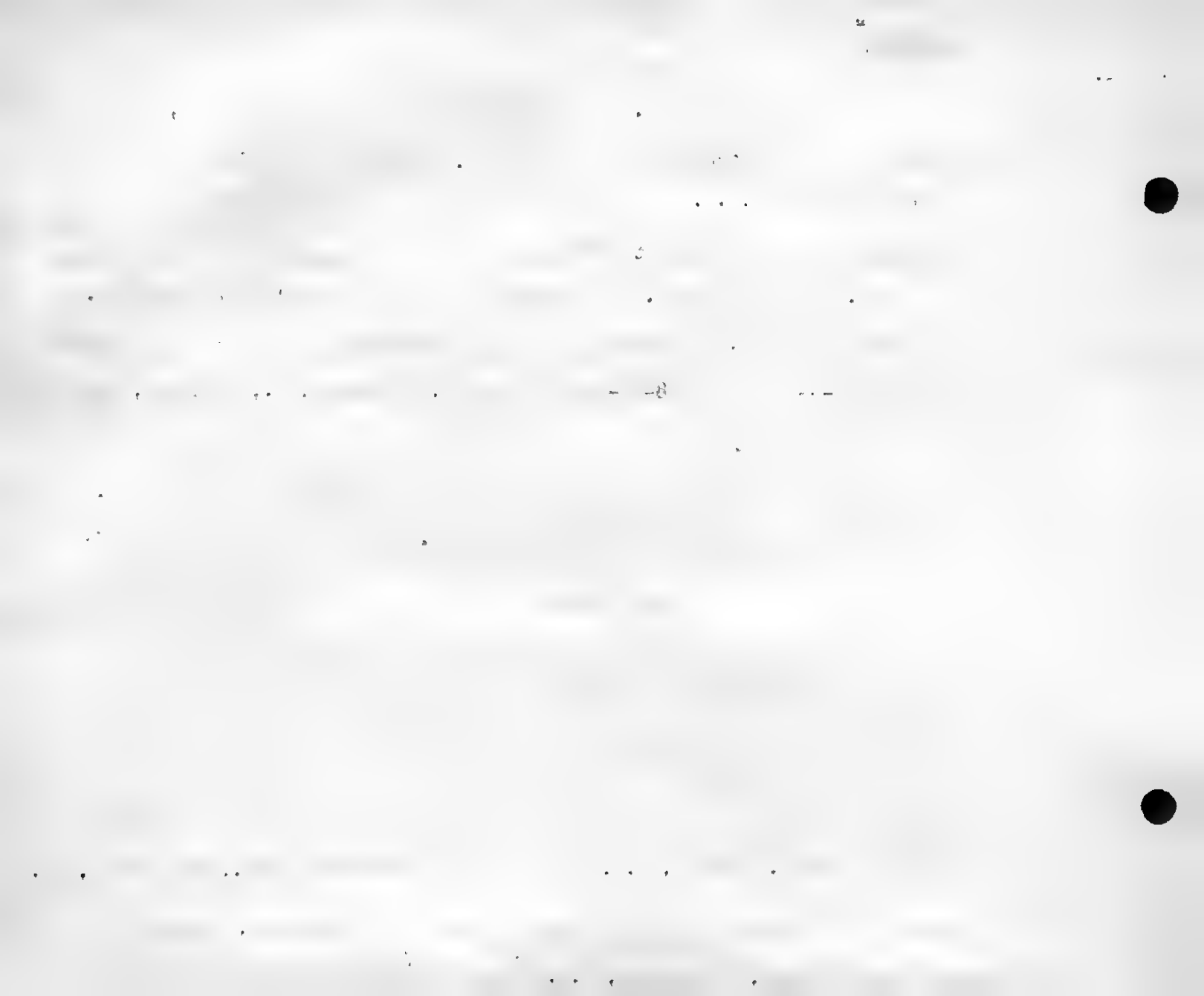
1. DECEASED NAME (Type or print) William Kemp Pace			2a. DATE OF DEATH Month 4 Day 12 Year 69		2b. HOUR 6:20AM
3. SEX male	4. RACE white	5. DATE OF BIRTH 4-17-88		6. AGE (In years last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? America	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MGH	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) heating contractor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Washington Grove		
14. FATHER'S NAME First William Middle H. Last Pace		15. MOTHER'S MAIDEN NAME First Arietta Middle Childs Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217 32 0960		17 INFORMANT William H. Pace 70 Skyline Dr. Morristown, N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bronche 36 hours 41x5 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive Heart Failure, Acute 3 days DUE TO, OR AS A CONSEQUENCE OF (c) A-I-F-D-					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Transitional Diverticulitis, Exfoliative Dermatitis, Cell Carcinoma					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Bladder	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l. medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 19 66 to APR-12-69 , that (I) (we) last saw the deceased alive on APR 11 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. my					
22b. SIGNATURE Jack Schumacher DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-12-69	
22d. PHYSICIAN'S NAME (Type) Jack Schumacher M. D.		22e. ADDRESS Russell Ave. Gaithersburg, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 14, 69	23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION (City or Town) (County) (State) Rockville Monte. Md.	
24. FUNERAL DIRECTOR Tyson Wheeler F. H. Rockville, Maryland		25a. REC'D BY REGISTRAR APR 15 1969		25b. REGISTRAR'S SIGNATURE William Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05708		CERTIFICATE OF DEATH						05703	
1. DECEASED-NAME (Type or print)		First ALMA	Middle K.	Last PALSGROVE		2a. DATE OF DEATH Month APRIL Day 9 Year 1969		2b. HOUR 6:30 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Dec. 1, 1886		6. AGE (In years lost 1/2 day) 82 YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		COUNTY OF DEATH Montgomery		Md	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Va.		13b. COUNTY Arl.		13c. CITY OR TOWN Arlington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4501 Arlington Blvd.	
14. FATHER'S NAME First John Middle P. Last Koerner		5. MOTHER'S MAIDEN NAME First Margaret Middle -- Last Krupp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 578-09-7242		17. INFORMANT Address John E. Palsgrove, Sr., Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchopneumonia +369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cerebro-vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Gen'l. arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 3 weeks 5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1940 , 19____, to 4/9 , 19 69 , that (I) (we) last saw the deceased alive on 4/8/69 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE John E. Everett		DEGREE John E. Everett, M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 4/9/69			
22d. PHYSICIAN'S NAME (Type) John E. Everett, M.D.		22e. ADDRESS 9400 Connecticut Ave., Kensington, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/14/69		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		5130 Wisconsin Ave, NW ADDRESS		25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by medical examiner J.C.

05709		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05704	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First		Middle		Last		Month	Day
NELL		MAE		PLAYER		4	12
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)	
Female		Caucasian		Nov. 3, 1907		62 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
N. C.		United States				Montgomery County Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Mellwood Farms		Press Officer		U. S. Government	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Washington, D.C.						730 24th St., N. W.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/>		16b. SOCIAL SECURITY NO	
First		Middle		Last		Address	
Calvin		Millard		Caudill		Lucina Sirnetta Myers	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
William Blair Player		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion		3 minutes			
		DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease		5+ years			
		DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular Disease					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-1, 1969, to 4-12, 1969, that (I) (we) last saw the deceased alive on 4-12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
H. S. Cresswell, Jr.				W. F. Cresswell, Jr.			
22e. ADDRESS		22f. ADDRESS		22g. ADDRESS			
2029 Q. St., NW		Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		4/15/69		Cedar Hill Cemetery		Suitland, Maryland	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, 5130 Wisconsin Av., NW		APR 15 1969		Charles Judge			
Washington, D.C.							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05710

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05710

1. DECEASED-NAME (Type or Print)			First Anna			Middle Barbara			Last PLUMMER			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 4 5 1969			2b. HOUR 10 ⁰⁰ PM																				
3. SEX F		4. RACE W		5. DATE OF BIRTH Jan 3 1919		6. AGE (In years last birthday) 50 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year April 6 1969			2d. HOUR 12 ³⁰ PM																				
7a. BIRTHPLACE (State or foreign country) Penn				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.																							
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4837 Battery Lane								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk				12b. KIND OF BUSINESS OR INDUSTRY C. I. A.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Montgomery				13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4857 Battery Lane, Bethesda																					
14. FATHER'S NAME First Middle Last Franklin P Albright						15. MOTHER'S MAIDEN NAME First Middle Last Anna Barbara Dubbs						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WWII						16b. SOCIAL SECURITY NO. 200-10-9963						17. INFORMANT James F Plummer						ADDRESS 4853 Cordell Ave. Bethesda, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Insufficiency</u> 41a DUE TO, OR AS A CONSEQUENCE OF <u>Coronary stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) years																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No				City or Town				County				State															
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John G. Ball						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Bethesda, Md						22b. DATE SIGNED April 7, 1969																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 4-9-69				23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville, Mont. Md																							
24. FUNERAL DIRECTOR Robert A Pumphrey						ADDRESS 7557 Wisconsin Ave Bethesda, Md						25a. REC'D BY REGISTRAR DATE APR 15 1969				25b. REGISTRAR'S SIGNATURE Charles Judge																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
05711												
CERTIFICATE OF DEATH												
05706												
1. DECEASED NAME (Type or print) JESSIE D. POOLE						2a. DATE OF DEATH Month APRIL Day 29 Year 69			2b. HOUR 6:45 AM			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH August 5 1891			6. AGE (in years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY Md.						
10. CITY OR TOWN OF DEATH BETHESDA				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR LANE NURSING & CONV. CENTER				12a. JSJA. OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 6013 BERSHIRE DRIVE		
14. FATHER'S NAME First HARRY Middle C Last DEAN				15. MOTHER'S MAIDEN NAME First Lillian Middle MAE Last BRACH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 578-12-2222		17. INFORMANT A. Wilbor Russell Poole			Address 6013 Berkshire Dr. Bethesda, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 11419 IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 2041 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48h												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Parkinson's Disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 69 , to 4/29 , 19 69 , that (I) (we) last saw the deceased alive on 4/28/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Ronald W. Barr						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) RONALD W. BARR, MD						22e. ADDRESS 10401 OLD GEORGETOWN Rd BETHESDA						
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE 5-2-69		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) Rockville		(County) Mont.		
24. FUNERAL DIRECTOR Robert A Pumphrey				25a. REC'D BY REGISTRAR MAY 5 1969		25b. REGISTRAR'S SIGNATURE Charles Judge						



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05712

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05707

1 DECEASED-NAME (Type or Print) <i>Ruby</i>		First <i>L.</i>	Middle <i>PRINCE</i>	Last	2a DATE KNOWN OF ESTI DEATH MATED <input type="checkbox"/> 4-27 1969	2b HOUR 3:55 PM
3 SEX <i>F</i>	4 RACE <i>White</i>	5 DATE OF BIRTH <i>11-23-19</i>	6 AGE (In years last birthday) <i>49</i> YRS	IF UNDER 1 YEAR MONTHS DAYS	7 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <i>4</i> - Day <i>27</i> - Year <i>1969</i>
7a BIRTHPLACE (State or foreign country) <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Bethesda</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <i>Odie</i>		First <i>Odie</i>	Middle <i>Lynch</i>	Last	15 MOTHER'S MAIDEN NAME <i>Annie E. Beall</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>579-12-5475</i>		17. INFORMANT <i>Scwell Prince</i>		ADDRESS <i>8716 Hartsdale Ave.</i>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Massive-sub-dural and intra-cerebral hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF <i>884X</i> Cond trans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Laceration of brain, due to trauma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fall at home</i> left side of brain.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic alcoholism -</i>						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>8:15 PM 4/26 1969</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <i>Fall out of bed -</i>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) <i>AT HOME</i>		21f LOCATION Street or R.F.D. No. City or Town County State <i>8716 HARTSDALE AVE BETHESDA MONT MD</i>		
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John G Ball</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <i>April 28, 1969</i>
EXAMINER'S NAME (Type) <i>John G Ball Md</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county) <i>Bethesda, Md</i>		
23a BURIAL CREMATION REMOVAL (Specify) <i>Cremation</i>		23b DATE <i>5-1-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Suitland Pr. Geo Md</i>
24 FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		7557 W ADDRESS <i>Bethesda, Md</i>		25a REC'D BY REGISTRAR <i>MAY 5 1969</i>		25b REGISTRAR'S SIGNATURE <i>William J. [Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05713

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05708

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Patricia Ann Privette			2a. DATE OF DEATH Month Day Year April 7, 1969			2b. HOUR A.M. 8:05	
3 SEX Female		4. RACE Negro		5. DATE OF BIRTH 19 August 1955		6. AGE (In years last birthday) 13 YRS	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE North Carolina		13b. COUNTY Eagle Rock		13c. CITY OR TOWN Eagle Rock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Eagle Rock Post Office		14 FATHER'S NAME First Middle Last Milton D. Privette		15 MOTHER'S MAIDEN NAME First Middle Last Alice Mae Burns			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fluid and Electrolyte Imbalance DUE TO, OR AS A CONSEQUENCE OF Uremic Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF Renal Insufficiency, Chronic (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Months 8 Months 10 Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from 23 March, 1969, to 7 April, 1969, that (X) (we) last saw the deceased alive on 7 April, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alan Rider MD		22c. DATE SIGNED 7 April 1969		22d. PHYSICIAN'S NAME (Type) Alan Rider, M. D.			
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-11-69		23c. NAME OF CEMETERY OR CREMATORY W.W. CHAMBERS WASH. D.C.		23d. LOCATION (City or Town) (County) (State) RALEIGH N. CAROLINA	
24. FUNERAL DIRECTOR W.W. CHAMBERS		ADDRESS 1400 CHAPIN ST. N.W.		25a. REC'D BY REGISTRAR APR 11 1969		25b. REGISTRAR'S SIGNATURE J. J. Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

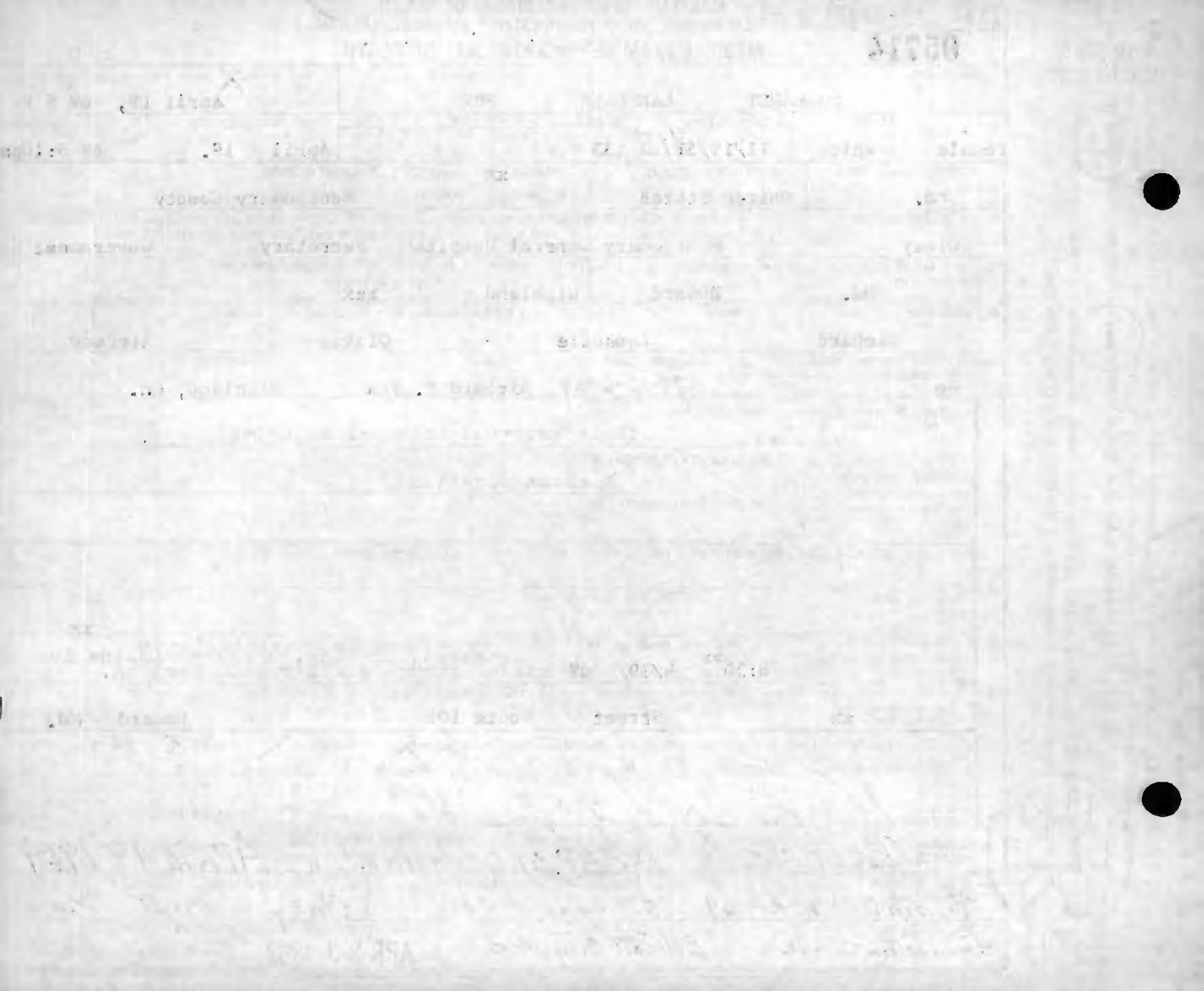
05714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05709

1. DECEASED-NAME (Type or Print) MARGARET LANSDALE PUE			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month April Day 19 Year 1969			2b. HOUR 9 PM				
3. SEX Female	4. RACE White	5. DATE OF BIRTH 11/19/1915	6. AGE (in years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April Day 19 Year 1969			2d. HOUR 9:10 PM	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Montgomery General Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Highland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Richard Middle Lansdale Last Lindsay			15. MOTHER'S MAIDEN NAME First Olivia Middle Lindsay Last Lindsay							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 579-16-6929		17. INFORMANT Richard F. Pue			ADDRESS Highland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple external internal injuries 8120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) with exsanguination DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 8:30 P.M. 4/19/1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased, driving, crossed midline in road & struck another auto head on.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. Route 108		City or Town Howard		County Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Belden R. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED APRIL 19 1969		
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		ADDRESS (City, Town, or County) Olney Mont. Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-22-69		23c. NAME OF CEMETERY OR CREMATORY St John E.P.'s		
24. FUNERAL DIRECTOR Higinbotham-Slack		ADDRESS Elliott City, Md.		25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

05774



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

05715		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05710					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR			
Frank			(none)		Quaife	Month 4 Day 13 Year 69		9P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
Male		White		4-14-1893		75 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Illinois		U. S. A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Kensington		300 McComas Ave		Gas Station Owner							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md		Montgomery		Kensington				11105 Waycross Way			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
George					Quaife	Mary					Reeder
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			---			355-03-37264 Mrs L Newton			11105 Waycross Way		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pulmonary Embolism										20 yrs.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
ASACU II, Chronic duodenal ulcer, carcinoma bladder.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION						
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 10/18, 1964, to 4/13, 1969, that (I) (we) lost the deceased alive on 4/13, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
Horace W Bernton MD											
22b. PHYSICIAN'S NAME (Type)		22c. ADDRESS			22d. ADDRESS						
Horace W Bernton MD		4743			Bradley Blvd Chevy Chase Md						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		4-17-69		St. Marys Cemetery		Streator, Ill.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A Pumphrey						7557 Wisconsin Ave Bethesda Md		APR 21 1969		Robert A Pumphrey	

(Name)

(Address)

11-1-1905

11-1-1905

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